SELF-SUFFICIENCY PROGRAM

July 1, 2023 PROPOSED RULE CHANGES

Divisions 461-150 through 461-195

ODHS RAC Packet for Section 3 of 3

Date: March 9, 2023

Time: 2:45 p.m. – 4:45 p.m.

Zoom Meeting Link:

https://www.zoomgov.com/j/1607744922?pwd=Q25LcTQ5Wlc4RTRiWTU0MmplNnNadz09

Phone Option English Line: 1-669-254-5252

Phone Option Spanish Line: 1-415-449-4000

Zoom & Phone Meeting ID: 160 774 4922

Zoom & Phone Passcode: 086043

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Summary of the Rule Changes

These rules are being repealed to move the Employment Related Day Care (ERDC) program from the authority of the Oregon Department of Human Services (ODHS) to the Department of Early Learning and Care (DELC), as required by House Bill 3073 (2021 regular session).

Need for the Rule Changes

These rules need to be repealed to remove the ERDC program from Chapter 461 of ODHS as required by House Bill 3073 (HB 3073 from 2021 regular session). HB 3073 increases access to affordable, high-quality learning experiences and supports for children and families by establishing a new early learning agency. HB 3073 directs the transfer of the ERDC program from ODHS to DELC. Repealing these rules will bring ODHS into compliance with HB 3073.

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Summary of the Rule Changes
These rules are being amended to remove the ERDC program from Chapter 461 to transfer it from ODHS to DELC as required by House Bill 3073 (2021 regular session).

Need for the Rule Changes
These rules need to be amended to remove the ERDC program. House Bill 3073 transfers the governance of the ERDC program from ODHS to DELC. HB3073 also increases access to affordable, high-quality learning experiences and supports for children and families by establishing a new early learning agency. These rule changes will bring ODHS into compliance with the legislated program transfer. DELC will draft and adopt rules that govern ERDC under Chapter 414.

Rules Proposed for Amendment in Chapter 461 Division 195, including Summary and Need Statements

- 461-195-0301 about Definitions for division 195 (pgs 98-99)
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Summary of the Rule Changes
These rules in division 461-195 are being amended to add DELC to the definition of "Department" and add DELC Oregon Administrative Rule references, which align the rules with DELC and OPAR Interagency Agreement. OAR 461-195-0621 is also being amended to prevent the Department from establishing an overpayment for an amount above restitution ordered by a court.

Need for the Rule Changes
These rules in division 461-195 need to be amended to make clear that authority and handling of ERDC overpayments and intentional program violations will remain with Office of Payment and Recovery per Interagency Agreement.

Draft Department Fiscal Impact Statement for all Rules

The Oregon Department of Human Services (ODHS) estimates no fiscal impact to the Department. ODHS will see a reduction of $127,926,690, a combination of general and federal funding for the 2023-2025 biennium, as these funds will be transferred to the Department of Early Learning and Care (DELC). ODHS will also reduce their position funding levels by $528,841 for the 2023-25 biennium. However, these funds were used to pay the direct provider payments or ODHS ERDC positions, which ODHS will no longer be responsible to pay. Therefore, there will be no impact to the overall ODHS budget.

The Department estimates no fiscal impact to DELC, which will not exist until July 2023. The positive fiscal impact to DELC by the movement of the funds from ODHS to DELC will be offset by the unchanged cost of payments and staffing that DELC will be responsible to pay.

The Department estimates no fiscal impact to ERDC program applicants, recipients, or providers; local government; small businesses including providers who consider themselves a small business; and large business. There is no cost of compliance for small business.

Draft Department Racial Equity Impact Statement for all Rules

The Department estimates no impact to racial equity in Oregon through the ERDC program transfer from ODHS to DELC. Governance of the program is moving under the authority of DELC as mandated by HB3073. The Department estimates no change in the application process, provider payments, or eligibility provisions during the transfer, however, beginning July 1, 2023, ODHS will have no authority as to how DELC implements the ERDC program.

461-155-0150 ~~Temporary~~ Eff. ~~01/09~~07/01/23
Child Care Provider Eligibility Standard, Payment Rates, Payment Limits, and Payable Hours

THIS RULE IS REPEALED

[The following provisions apply to child care in the ERDC, JOBS, JOBS Plus, and TANF programs:

(1) The following definitions apply to the rules governing child care rates:

(a) Infant: For all providers other than licensed (registered or certified) care, a child aged newborn to 1 year. For licensed care, an infant is a child aged newborn to 2 years.

(b) Toddler: For all providers other than licensed (registered or certified) care, a child aged 1 year to 3 years. For licensed care, a toddler is a child aged 2 years to 3 years.

(c) Preschool: A child aged 3 years to 6 years.

(d) School: A child aged 6 years or older.

(e) Special Needs: A child who meets the age requirement of the program and who requires a level of care over and above the norm for their age due to a physical, behavioral, or mental disability. The disability must be verified by one of the following:

(A) A physician, nurse practitioner, clinical social worker, or any additional sources in OAR 461-125-0830.

(B) Eligibility for Early Intervention and Early Childhood Special Education Programs, or school-age Special Education Programs.

(C) Eligibility for SSI.

(2) The following definitions apply to the types of care specified in the child care rate charts in subsections (4)(a) through (4)(c) of this rule:

(a) The *Standard Family Rate* applies to child care provided in the provider's own home or in the home of the child when the provider does not qualify for the enhanced rate allowed by subsection (b) of this section.

(b) The *Enhanced Family Rate* applies to child care provided in the provider's own home or in the home of the child when the provider meets the training

requirements of the Oregon Registry, established by the Oregon Center for Career Development in Childhood Care and Education.

(c) The *Registered Family Rate* applies to child care provided in the provider's own home when the provider meets criteria established by the Office of Child Care.

(d) The *Certified Family Rate* applies to child care provided in a residential dwelling that is certified by the Office of Child Care as a Certified Family Home. To earn this designation, the facility must be inspected, and both provider and facility are required to meet certain standards not required of a registered family provider.

(e) The *Standard Center Rate* applies to child care provided in a facility that is not located in a residential dwelling and is exempt from Office of Child Care Certification rules (see OAR 414-300-0000).

(f) The *Enhanced Center Rate* applies to child care provided in an exempt center whose staff meet the training requirements of the Oregon Registry established by the Oregon Center for Career Development in Childhood Care and Education. Eligibility to receive the enhanced center rate for care provided in an exempt center is subject to the following requirements:

(A) A minimum of one staff member for every 20 children in care must meet the Oregon Registry training requirements noted in subsection (b) of this section.

(B) New staff must meet the Oregon Registry training requirements within 90 days of hire, if necessary to maintain the trained staff-to-children ratio described in paragraph (A) of this subsection.

(C) There must be at least one person present where care is provided who has a current certificate in infant and child CPR and a current American Red Cross First Aid card or an equivalent.

(g) An enhanced rate will become effective not later than the second month following the month in which the Department receives verification that the provider has met the requirements of subsection (b) or (f) of this section.

(h) The *Certified Center Rate* applies to child care provided in a center that is certified by the Office of Child Care or participating in the Alternative Pathway program through the Office of Child Care.

(3) The following provisions apply to child care payments:

(a) Providers not eligible for the enhanced or licensed rate will be paid at an hourly rate for children in care less than 158 hours per month subject to the maximum full-time monthly rate.

(b) Providers eligible for the enhanced or licensed rate will be paid at an hourly rate for children in care less than 136 hours a month, unless the provider customarily bills all families at a part-time monthly rate subject to the maximum full-time monthly rate and is designated as the primary provider for the case.

(c) At their request, providers eligible for the enhanced or licensed rate may be paid at the part-time monthly rate if they provide 63 or more hours of care in the month, customarily bill all families at a part-time monthly rate, and are designated as the primary provider for the case.

(d) Unless required by the circumstances of the caretaker or child, the Department will not pay for care at a part-time monthly or a monthly rate to more than one provider for the same child for the same month.

(e) The Department will pay at the hourly rate for less than 63 hours of care in the month subject to the maximum full-time monthly rate.

(f) The Department will pay for absent days each month the child is absent. Absent days can be billed if:

(A) It is the provider's policy to bill all families for absent days; and

(B) The child was scheduled to be in care, the provider bills for the amount of time the child was scheduled to be in care, and the child has not been absent for a calendar month.

(g) Child care providers are eligible to receive an incentive payment upon achieving and maintaining a three star or higher rating with the Quality Rating Improvement System (QRIS) subject to all of the following provisions.

(A) The incentive payment is in addition to the Department maximum rate.

(B) A provider may receive an incentive payment for any ERDC child that the Department paid the provider for full-time care (136 hours or more).

(C) Providers who are contracted for child care services through the ERDC program are not eligible to receive incentive payments, with the exception of Early Head Start providers.

(D) Eligibility for the incentive payment is effective the month after the QRIS rating has been achieved.

(E) The incentive payment amount is based on the provider's star QRIS rating as follows:

Star Rating…….Amount
3……$54
4……$72
5……$90

(h) In the ERDC program, child care providers eligible for the licensed rate may receive payment from the Department for registration and other fees if they are required by the facility for a child to begin or continue care and the fees are also required of the general public. Fees related to penalties, fines, charges exceeding approved ERDC hours or rates (see section (4) of this rule), or advance payment for cost of care are not eligible for payment.

(4) Effective June 1, 2022, the following are the child care rates based on the type of provider, the location of the provider (shown by zip code), the age of the child, and the type of billing used (hourly or monthly):

(a)

Group Area A
STANDARD RATE MAXIMUMS (Not Licensed)

	Standard Family Rate		Standard Center Rate	
	1-157 Hours per month	158-215 Hours per month	1-157 Hours per month	158-215 Hours per month
	Hourly	Monthly	Hourly	Monthly
Infant	$4.48	$830	$9.00	$1,279
Toddler	$4.43	$797	$7.50	$1,279
Preschool	$4.43	$747	$8.25	$1,050
School	$4.43	$740	$5.63	$825
Special Needs	$4.48	$830	$9.00	$1,279

ENHANCED RATE MAXIMUMS (Not Licensed)

	Enhanced Family Rate			Enhanced Center Rate		
	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	$4.82	$653	$871	$10.20	$1,087	$1,449
Toddler	$4.55	$627	$835	$8.50	$1,087	$1,449
Preschool	$4.55	$593	$791	$9.35	$893	$1,190
School	$4.49	$559	$746	$6.38	$701	$935
Special Needs	$4.82	$653	$871	$10.20	$1,087	$1,449

LICENSED RATE MAXIMUMS

	Registered Family Rate			Certified Family Rate			Certified Center Rate		
	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	$6.00	$814	$1,085	$6.50	$1,238	$1,650	$12.00	$1,279	$1,705
Toddler	$5.00	$720	$960	$7.00	$1,176	$1,568	$10.00	$1,279	$1,705
Preschool	$5.50	$675	$900	$6.00	$956	$1,275	$11.00	$1050	$1,400
School	$5.00	$563	$750	$6.00	$750	$1,000	$7.50	$825	$1,100
Special Needs	$6.00	$814	$1,085	$6.50	$1,238	$1,650	$12.00	$1,279	$1,705

Zip Codes for Group Area A:
Portland, Bend, Eugene, Corvallis, Springfield, Monmouth and Ashland areas

97003	97004	97005	97006	97007	97008	97009	97010	97013	97014	97015	97019
97022	97023	97024	97027	97028	97030	97031	97034	97035	97036	97041	97045
97051	97055	97056	97060	97062	97064	97068	97070	97080	97086	97089	97106
97109	97112	97113	97116	97119	97123	97124	97125	97132	97133	97135	97140
97149	97201	97202	97203	97204	97205	97206	97209	97210	97211	97212	97213
97214	97215	97216	97217	97218	97219	97220	97221	97222	97223	97224	97225
97227	97229	97230	97231	97232	97233	97236	97239	97242	97258	97266	97267
97268	97286	97292	97330	97331	97333	97339	97351	97361	97371	97376	97401
97402	97403	97404	97405	97408	97454	97455	97477	97478	97482	97520	97525
97701	97702	97703	97707	97708	97709	97078					

(b)

Group Area B
STANDARD RATE MAXIMUMS (Not Licensed)

	Standard Family Rate		Standard Center Rate	
	1-157 Hours per month	158-215 Hours per month	1-157 Hours per month	158-215 Hours per month
	Hourly	Monthly	Hourly	Monthly
Infant	$3.88	$663	$4.88	$893
Toddler	$3.88	$636	$4.69	$812
Preschool	$3.68	$630	$4.31	$645
School	$3.68	$611	$3.86	$472
Special Needs	$3.88	$663	$4.88	$893

ENHANCED RATE MAXIMUMS (Not Licensed)

	Enhanced Family Rate			Enhanced Center Rate		
	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	$4.08	$535	$714	$5.53	$759	$1,012
Toddler	$4.08	$510	$680	$5.31	$690	$921
Preschool	$4.08	$510	$680	$4.89	$548	$731
School	$4.08	$478	$637	$4.38	$401	$535
Special Needs	$4.08	$535	$714	$5.53	$759	$1,012

LICENSED RATE MAXIMUMS

	Registered Family Rate			Certified Family Rate			Certified Center Rate		
	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	$4.50	$563	$750	$5.00	$750	$1,000	$6.50	$893	$1,190
Toddler	$4.00	$525	$700	$5.00	$675	$900	$6.25	$812	$1,083
Preschool	$4.00	$510	$680	$5.75	$638	$850	$5.75	$645	$860
School	$4.00	$488	$650	$5.75	$563	$750	$5.15	$472	$629
Special Needs	$4.50	$563	$750	$5.00	$750	$1,000	$6.50	$893	$1,190

Zip Codes for Group Area B:
Salem, Medford, Roseburg, Brookings and areas outside the metropolitan areas in Eugene and Portland

97002		97011	97016	97017	97018	97038	97042	97044	97048	97049	97053
97058	97067	97071	97103	97107	97108	97110	97111	97114	97115	97117	97118
97121	97122	97127	97128	97131	97134	97138	97141	97143	97146	97148	97301
97302	97303	97304	97305	97306	97307	97309	97310	97317	97321	97322	97325
97326	97327	97328	97336	97338	97341	97343	97344	97348	97352	97353	97355
97357	97362	97365	97366	97367	97370	97372	97374	97377	97378	97380	97381
97383	97385	97386	97389	97391	97392	97394	97415	97420	97423	97424	97426
97431	97444	97446	97448	97452	97456	97457	97459	97465	97470	97471	97479
97487	97489	97501	97502	97503	97504	97524	97534	97535	97756	97759	97760
97801	97812	97813									

(c)

Group Area C
STANDARD RATE MAXIMUMS (Not Licensed)

	Standard Family Rate		Standard Center Rate	
	1-157 Hours per month	158-215 Hours per month	1-157 Hours per month	158-215 Hours per month
	Hourly	Monthly	Hourly	Monthly
Infant	$3.88	$663	$4.88	$893

Toddler	$3.88	$636	$4.69	$812
Preschool	$3.68	$630	$4.31	$645
School	$3.68	$611	$3.86	$472
Special Needs	$3.88	$663	$4.88	$893

ENHANCED RATE MAXIMUMS (Not Licensed)

	Enhanced Family Rate			Enhanced Center Rate		
	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	$4.08	$535	$714	$5.53	$759	$1,012
Toddler	$4.08	$510	$680	$5.31	$690	$921
Preschool	$4.08	$510	$680	$4.89	$548	$731
School	$4.08	$478	$637	$4.38	$401	$535
Special Needs	$4.08	$535	$714	$5.53	$759	$1,012

LICENSED RATE MAXIMUMS

	Registered Family Rate			Certified Family Rate			Certified Center Rate		
	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month	1-62 Hours per month	63-135 Hours per month	136-215 Hours per month
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	$4.50	$563	$750	$5.00	$750	$1,000	$6.50	$893	$1,190
Toddler	$4.00	$525	$700	$5.00	$675	$900	$6.25	$812	$1,083
Preschool	$4.00	$510	$680	$5.75	$638	$850	$5.75	$645	$860
School	$4.00	$488	$650	$5.75	$563	$750	$5.15	$472	$629
Special Needs	$4.50	$563	$750	$5.00	$750	$1,000	$6.50	$893	$1,190

Zip Codes for Group Area C: Balance of State, Other State Zips

97001	97020	97021	97026	97029	97032	97033	97037	97039	97040	97050	97054	97057
97063	97065	97101	97102	97130	97136	97137	97144	97145	97147	97324	97329	97335
97342	97345	97346	97347	97350	97358	97359	97360	97364	97368	97369	97375	97384
97388	97390	97396	97406	97407	97409	97410	97411	97412	97413	97414	97416	97417
97419	97425	97427	97428	97429	97430	97432	97433	97434	97435	97436	97437	97438
97439	97441	97442	97443	97447	97449	97450	97451	97453	97458	97460	97461	97462
97463	97464	97466	97467	97468	97469	97472	97473	97476	97480	97481	97484	97486
97488	97490	97491	97492	97493	97494	97495	97496	97497	97498	97499	97522	97523
97526	97527	97530	97531	97532	97533	97536	97537	97538	97539	97540	97541	97543
97544	97601	97603	97604	97620	97621	97622	97623	97624	97625	97626	97627	97630
97632	97633	97634	97635	97636	97637	97638	97639	97640	97641	97710	97711	97712
97720	97721	97722	97730	97731	97732	97733	97734	97735	97736	97737	97738	97739
97740	97741	97742	97750	97751	97752	97753	97754	97758	97761	97810	97814	97817
97818	97819	97820	97821	97822	97823	97824	97825	97826	97827	97828	97830	97831
97833	97834	97835	97836	97837	97838	97839	97840	97841	97842	97843	97844	97845
97846	97848	97850	97856	97857	97859	97861	97862	97864	97865	97867	97868	97869
97870	97871	97872	97873	97874	97875	97876	97877	97880	97882	97883	97884	97885
97886	97901	97902	97903	97904	97905	97906	97907	97908	97909	97910	97911	97913
97914	97918	97919	97920									

(5) OAR 461-160-0300 establishes ERDC financial *eligibility,* allowable child care cost, and the copay calculation, except for child care under a contract between a Head Start agency and the Department, which is covered under OAR 461-135-0405.

(6) Subject to the provisions in section (9) of this rule, the monthly limit for each child's child care payments is the lesser of the amount charged by the provider or providers and the following amounts:

(a) The monthly rate provided in section (4) of this rule.

(b) The product of the hours of care, limited by section (8) of this rule, multiplied by the hourly rate provided in section (4) of this rule.

(7) The limit in any month for child care payments on behalf of a child whose caretaker is away from the child's home for more than 30 days because the caretaker is a member of a reserve or National Guard unit that is called up for active duty is the lesser of the following:

(a) The amount billed by the provider or providers.

(b) The monthly rate established in this rule for 215 hours of care.

(8) The number of payable billed hours of care for a child is limited as follows:

(a) In the ERDC and TANF programs, the total payable hours of care in a month may not exceed the amounts in paragraphs (A) or (B) of this subsection:

(A) 125 percent of the number of child care hours authorized:

(i) Under OAR 461-160-0040(3), (6), and (7); or

(ii) To participate in activities included in a *case plan* (see OAR 461-001-0025) including, for caretakers in the JOBS Plus program, the time the caretaker searches for unsubsidized employment and for which the employer pays the caretaker.

(B) The monthly rate established in section (4) of this rule multiplied by a factor of not more than 1.5, determined by dividing the number of hours billed by 215, when the caretaker meets the criteria for extra hours under section (10) of this rule.

(b) In the ERDC program, for a caretaker who earns less than the Oregon minimum wage, the total may not exceed 125 percent of the anticipated earnings divided by the state minimum wage not to exceed 172 hours (which is full time).

(c) In the TANF program, for a caretaker who earns less than the Oregon minimum wage or is self-employed, the total may not exceed 125 percent of the anticipated earnings divided by the state minimum wage not to exceed 172 hours (which is full time). The limitation of this subsection is waived for the first three months of the caretaker's employment.

(9) The limit in any month for child care payments on behalf of a child whose caretaker has special circumstances, defined in section (10) of this rule, is the lesser of one of the following:

(a) The amount billed by the provider or providers; or

(b) The monthly rate established in section (4) of this rule multiplied by a factor, of not more than 1.5, determined by dividing the number of hours billed by 215.

(10) The limit allowed by section (9) of this rule is authorized once the Department has determined the caretaker has special circumstances. For the purposes of this section, a caretaker has special circumstances when it is necessary for the caretaker to obtain child care in excess of 215 hours in a month to perform the requirements of their employment or training required to keep current employment, not including self-employment. This is limited to the following situations:

(a) The commute time to and from work or education settings exceeds two hours per day.

(b) The caretaker has an overnight shift and care is necessary for both shift hours and sleep hours.

(c) Retroactively effective January 1, 2023, multiple caretakers need care for both shift hours and sleep hours when:

(A) There is overlap in the caretakers' reported hours, and

(B) At least one caretaker works an overnight shift.

(d) The caretaker has a split shift and it is not feasible to care for the child between shifts.

(e) The caretaker consistently works, participates in education hours, or both, more than 40 hours per week.

(11) The payment available for care of a child who meets the special needs criteria described in subsection (e) of section (1) of this rule is increased in accordance with OAR 461-155-0151 if the requirements of both of the following subsections are met:

(a) The child requires significantly more direct supervision by the child care provider than normal for a child of the same age.

(b) The child is enrolled in a local school district Early Intervention or Early Childhood Special Education program or school-age Special Education Program. The enrollment required by this subsection is waived if determined inappropriate by a physician, nurse practitioner, licensed or certified psychologist, clinical social worker, or school district official.]

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 412.006, 412.049
Statutes/Other Implemented: ORS 329A.500, 409.010, 409.610, 411.060, 411.070, 411.122, 411.141, 412.006, 412.049, 412.124, 418.485, HB 4005 2022 Reg. Sess. (Oregon 2022), HB 3073 Oregon 2021 Regular Sess.

461-155-0151 Eff. ~~01/26/22~~07/01/23
High Special Needs; Child Care

THIS RULE IS REPEALED

[(1) The payment authorized by OAR 461-155-0150(11) is calculated by adding the applicable special need payment authorized by section (4) of that rule to the additional amount determined by this rule.

(2) The additional amount determined by this rule is allowed in consideration of the additional cost to a child care provider for the additional care and supervision required because of a child's physical, mental or behavioral condition. To determine the additional amount, a factor ranging from 0 to 2, determined by this rule is multiplied by:

(a) $5.00 for a payment calculated on an hourly basis; or

(b) $840 for a payment calculated on a monthly basis.

(3) The factor used to make the calculation described in section (2) of this rule is determined by first establishing a score for each category listed in section (5) of this rule. The score is established by multiplying a rating and the weight for each category. The weight is given in section (5). The rating is determined as follows:

(a) The child's need for care and supervision is assessed and is compared with the needs of other children of the same age, and a rating is determined for each category. The rating is a whole number from zero to ten.

(b) Benchmark scores are given in section (5) of this rule for each category using several descriptions of need. The child's level is matched with the benchmark descriptions, and a rating is assigned based on a comparison of the child's needs and the benchmark descriptions. If a child's level of need falls between---or is described in part by---two benchmarks in the rule, an appropriate intermediate rating is assigned based on the benchmarks scores.

(4) After a score is determined for each category, the scores are added. The sum of the scores is changed to 100 if it is less than 110 and is reduced to 300 if it exceeds 300. The adjusted score is decreased by 100, and the remainder is divided by 100. The result is the factor used in section (2) of this rule.

(5) The categories, their weights, and standards for their ratings are as follows:

(a) Level of medical care---weight is 7:

(A) Child requires on-site medical attention by a licensed medical or mental health professional and the child care provider must have specialized training related to the child's medical or mental health needs---rating of 10.

(B) The provider must have specialized training related to the child's medical or mental health needs and consults frequently with a medical or mental health professional---rating of 8.

(C) Child requires medical attention by a caregiver who has received some specialized training related to the child's medical or mental health needs---rating of 4.

(D) Child requires medical attention or monitoring by a caregiver who has received special instructions from the parent or a service provider related to the child's medical or mental health needs---rating of 1.

(E) Child's needs can be met by staff with general knowledge---rating of zero.

(b) Self-sufficiency with daily tasks---weight is 5:

(A) Child requires total assistance with eating or toileting, such as requiring tube feedings or with special toileting needs, such as ostomy care---rating of 10.

(B) Child requires considerable assistance in eating or toileting---rating of 5.

(C) Child requires only minor assistance with eating or toileting---rating of 1.

(D) Child can take care of daily tasks with very little assistance---rating of zero.

(c) Mobility---weight is 5:

(A) Child is unable to help with positioning or movement, needs frequent repositioning, and the child is difficult to move---rating of 10.

(B) Child can help with transfers, pivoting and position---rating of 5.

(C) Child is able to move independently with minor support---rating of 1.

(D) Child's mobility is similar to other children of the same age---rating of zero.

(d) Communication skills---weight is 6:

(A) Child is unable to communicate needs and wants, and is unable to use alternative communication methods---rating of 10.

(B) Child relies entirely upon alternative methods such as sign language, picture boards, gestures, or facial expressions, to communicate the child's needs or to understand requests made of the child---rating of 8.

(C) Child has limited verbal skills. The child may require one-on-one communication to gain the child's attention, simplify instructions, or to understand the child's speech or gestures. Child may use alternative methods, mentioned in paragraph (B) of this sub-section, as a supplement to verbal skills---rating of 4.

(D) Child's communication skills are roughly similar to other children of the same age---rating of zero.

(e) Need for monitoring and intervention---weight is 11:

(A) The child must remain within the child care provider's direct view at all times and needs frequent intervention to prevent harm to self or other children---rating of 10.

(B) The child must remain within the provider's direct view at all times but does not need frequent intervention---rating of 7.

(C) Child has behaviors that frequently require adult intervention but are not a threat to the child's or other children's safety---rating of 4.

(D) Child needs assistance to initiate, respond to, or engage in peer interactions that are safe, positive, and appropriate---rating of 2.

(E) Child needs some assistance but generally does well if the assistance is provided---rating of zero.

(f) Cognition and comprehension---weight is 7:

(A) Child is unable to recognize danger, is unable to follow instructions without one-on-one assistance, and has difficulty processing basic sensory information about the environment. This does not include vision or hearing as the primary difficulty---rating of 10.

(B) Child needs to be given one instruction at a time and may need reminders of what was asked in order to complete instruction---rating of 5.

(C) Child is able to understand and solve problems with some special attention---rating of zero.

(g) Other special considerations---weight is 5. There are other considerations relating to the level of supervision required for the child that are not included in the above categories. A rating is determined based on how much more supervision the child needs---because of the other consideration---than other children of the same age.]

Statutory/Other Authority: 411.060

Statutes/Other Implemented: 411.060

461-160-0300 Eff. 7/01/232

THIS RULE IS REPEALED

[Use of Income to Determine Eligibility and Copay Benefits for ERDC

The Department determines financial *eligibility* (see OAR 461-001-0000) for ERDC and the copay benefit level as follows:

(1) ERDC financial *eligibility*.

(a) The *financial group* (see OAR 461-110-0530) may not exceed the resource limit in OAR 461-160-0015.

(b) The monthly *countable* (see OAR 461-001-0000 and 461-145-0930) gross income of the *financial group* is determined in accordance with OAR 461-150-0060. If monthly *countable* income equals or exceeds the eligibility standards, the *need group* (see OAR 461-110-0630) is ineligible for ERDC.

(A) At initial certification, the ERDC *eligibility* standard is met for a *need group* of eight or less if monthly *countable* income for the *need group* is less than 200 percent of the federal poverty level (FPL), as described in OAR 461-155-0180. The eligibility standard for a *need group* of eight applies to any *need group* larger than eight.

(B) During the *certification period* (see OAR 461-001-0000) and at recertification the ERDC eligibility standard is met for a *need group* of eight or less if monthly *countable* income for the *need group* during the 12 month period is less than 250 percent FPL or 85 percent state median income (SMI), whichever is higher, as described in OAR 461-155-0180. The eligibility standard for a *need group* of eight applies to any *need group* larger than eight.

(c) The copay calculated under section (3) of this rule is compared to the allowable child care cost under section (2) of this rule. If the copay is equal to or greater than the allowable child care cost, the client is not eligible for ERDC.

(2) Allowable Child Care Cost. For an individual found eligible under section (1) of this rule, the allowable child care cost is set under this section.

(a) The child care costs for which the client has been billed are compared to the amount provided in the appropriate child care chart in OAR 461-155-0150. The allowable child care cost is the lesser of the two amounts.

(b) The need group's copay is determined in accordance with section (3) of this rule.

(c) The copay is subtracted from the allowable child care cost, and the remainder is the payment the Department makes to the provider.

(3) Copay Calculation.

(a) A *need group* with a *certification period* that began in March 2020 through September 2021 shall have a monthly copay of $0 for the entirety of the *certification period*. The copay calculation for February 2020 and earlier is found in previous versions of OAR 461-155-0150.

(b) When determining the copay, upon the applicant's request, the Department may exclude at least 50 percent of gross self-employment income when a *need group* has *countable* self-employment income and permitted costs (see OAR 461-145-0910 and 461-145-0920). The maximum exclusion is the total of all actual costs permitted under OAR 461-145-0920.

(c) Effective March 1, 2022, the monthly copay shall be as follows, using the *countable* income, or *countable* self-employment income minus permitted costs:

Need group size of 2
Income……..Monthly Copay
$0 - $1525.99 ……...$0
$1526 - $2288.99 …….$5
$2289 - $3051.99 …….$10
$3052 - $3433.99 …….$40
$3434 - $4530.99 …….$100

Need group size of 3
Income……..Monthly Copay
$0 - $1919.99 ……...$0
$1920 - 2878.99 ……..….$5
$2879 - $3358.99 …….$10
$3359 - $3838.99 …….$15
$3839 - $4318.99 …….$50
$4319 - $5595.99 …….$110

Need group size of 4
Income……..Monthly Copay
$0 - $2312.99 ……....$0
$2313 - $3468.99…….$5
$3469 - $4046.99…….$10
$4047 - $4624.99…….$20
$4625 - $5203.99…….$60
$5204 - $6661.99…….$120

Need group size of 5

Income……..Monthly Copay
$0 - $2705.99……...$0
$2706 - $4058.99…….$5
$4059 - $4735.99…….$10
$4736 - $5411.99…….$25
$5412 - $6088.99…….$70
$6089 – $7727.99…….$130

Need group size of 6
Income……..Monthly Copay
$0 - $3099.99……...$0
$3100 - $4648.99…….$5
$4649 - $5423.99…….$10
$5424 - $6198.99…….$25
$6199 - $6973.99…….$70
$6974 - $8793.99…….$130

Need group size of 7
Income……..Monthly Copay
$0 - $3492.99……...$0
$3493 - $5238.99…….$5
$5239 - $6111.99…….$10
$6112 - $6984.99…….$25
$6985 - $7858.99…….$70
$7859 - $8993.99…….$130

Need group size of 8 or more
Income……..Monthly Copay
$0 - $3885.99……...$0
$3886 - $5828.99…….$5
$5829 - $6800.99…….$10
$6801 - $7771.99…….$25
$7772 - $8743.99…….$70
$8744 - $9714.99…….....$130

(d) Notwithstanding the provisions of this rule section, the ERDC copay may be reduced or temporarily waived as follows:

(A) Reduced to $0 for no more than three months after closure of TANF benefits when:

(i) The closure is because an individual in the *need group* had earned income that led to the TANF closure;

(ii) An ERDC *date of request* (see OAR 461-115-0030) is established within 90 days of closure; and

(iii) The individual is eligible for ERDC at initial certification.

(B) As allowed under OARs 461-160-0040 and 461-135-0405.]

Statutory/Other Authority: ORS 411.060
Statutes/Other Implemented: ORS 409.610, 411.060, 411.122

461-165-0160 Eff. ~~01/26/22~~07/01/23
Direct Provider Payments; General Information

THIS RULE IS REPEALED

[(1) The Department makes payments on behalf of eligible clients to the providers they select to care for their children. The payments are made directly to the provider. To be eligible for payment, a provider must:

(a) Charge Department clients at a rate no higher than the rate charged other customers;

(b) Provide the Department their social security number (SSN) or IRS identification number; and

(c) Meet the requirements of OAR 461-165-0180.

(2) Payments to a client's provider are subject to each of the following limitations:

(a) Before August 1, 2021, payment is made only for child care already provided in the TANF program for all providers. Before August 1, 2021, payment is made for child care already provided in the ERDC program for all providers except Certified Centers certified by the Office of Child Care who receive payment in advance for anticipated hours a child is in care for the month.

(b) Payment is made for the amount charged to the client but may not exceed the rate authorized in OAR 461-155-0150.

(c) No payment will be authorized unless the client has designated a primary provider.

(d) No payment will be made for less than one dollar.

(e) Except as provided otherwise in subsection (f) of this section, a payment is made only for child care provided on or after the date the designated provider has met the requirements to be listed and paid through the Department.

(f) A designated child care provider who the Department approves to be listed and paid through the Department may receive payment for child care provided prior to obtaining Department approval if the provider met the other Department requirements and was licensed under OAR 414-205-0000 to 414-205-0170, OAR 414-350-0000 to 414-350-0405, or OAR 414-300-0000 to 414-300-0415.

(g) Beginning July 1, 2021, a *caretaker* (see OAR 461-001-0000) signature is not required on child care billing forms.

(h) Beginning August 1, 2021, a provider caring for an eligible child in the TANF or ERDC programs may receive payment in advance for hours the child is scheduled to be in care for the month.

(3) In the ERDC and TANF programs, the Department may issue a payment to an eligible provider during a month for which child care is being provided to meet an unexpected need of the provider related to the care of a covered child. The payment may be made if, without the payment, continued care by the same provider would be jeopardized and the client could not immediately obtain child care from another provider.]

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.122, 412.049
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.122, 412.049, 45 CFR 98.45

461-165-0171 Eff. ~~7-1-~~
~~11~~07/01/23
Direct Provider Payments; Payment Forms

THIS RULE IS REPEALED

[In the ERDC, JOBS, OFSET, and TANF programs:

(1) Child care providers must submit claims for child care on the appropriate form or through the Child Care Billing and Attendance Tracking system.

(a) The provider is responsible to obtain the appropriate payment form from the Department and to return the completed form to the Direct Pay Unit of the Department; or

(b) If using the Department tracking system, the provider is responsible to ensure children are checked in and out appropriately and payment requests are submitted through the system.

(2) No payment will be made for --

(a) A paper claim not received by the Department by the last day of the third month after the form was issued unless the Department determines the provider had good cause for not returning the form timely.

(b) An electronic claim if the request is not submitted by the 10th of the month following the month care is provided unless the Department determines the provider has good cause for not submitting the electronic claim timely.]

Stat. Auth.: 411.060, 411.070, 411.816, 412.006, 412.049
Stats. Implemented: 411.060, 411.070, 411.816, 412.006, 412.049

461-165-0180 Eff. 07~~1~~/01/23
Eligibility of Child Care Providers

THIS RULE IS REPEALED

[(1) The Department must approve a child care provider if information available to the Department provides no basis for denying eligibility unless it is determined that the provider or other *subject individual* (see OAR 125-007-0210, 407-007-0210(12)(a)(K), and 414-061-0030) is not eligible to provide care.

(2) The Department may approve a child care provider who is *legally exempt* (see section (11) of this rule) as a child care provider for a *child* (see OAR 461-001-0000) in their household, if all members of the household have an *enrollment* (see OAR 414-061-0010) or *limited enrollment* (see OAR 414-061-0010) in the *Central Background Registry* (see OAR 414-061-0020) and all of the following requirements are met:

(a) There is no criminal history consisting of a disqualifying crime listed in 45 CFR 98.43(c).

(b) The household member with the criminal or child abuse and neglect history is a *parent* (see OAR 461-001-0000) or *caretaker relative* (see OAR 461-001-0000) of the *child* needing child care.

(c) The child care is needed for the household member with the criminal or child abuse and neglect history to participate in the JOBS program, or the education or employment covered by the ERDC program.

(d) The approval for Department payments only applies for the *child* of the household member, or a *child* for whom the household member is a *caretaker relative*.

(3) Ineligibility for payment may result from any of the following and begins on the date of occurrence:

(a) A violation of a requirement under section (7) of this rule. When a provider fails to keep daily attendance records as required under subsection (7)(e) of this rule, the “date of occurrence” begins the day for which there is no required record.

(b) A finding of "denied".

(A) A provider may be "denied" if they are not enrolled in or are suspended from the *Central Background Registry* if they have submitted an application for enrollment in the *Central Background Registry* that has been denied for cause, or if they have been removed for cause from the *Central Background Registry* by final order of the Office of Child Care (OCC) and have not been re-enrolled. A *subject individual* who has been denied enrollment in the *Central Background Registry* due to a

determination of unsuitability shall not be eligible for enrollment in the *Central Background Registry* for five years from the date of denial.

(B) A *subject individual* may appeal OCC's determination not to enroll the *subject individual* in the *Central Background Registry*, pursuant to OAR 414-061-0120.

(c) A finding of "failed".

(A) A provider may be "failed" if the Department determines, based on a specific eligibility requirement and evidence, that a provider does not meet an eligibility requirement of this rule not covered in paragraph (c)(A) of this section.

(B) While the provider is in "failed" status:

(i) The Department does not pay any other child care provider for child care at the "failed" provider's site.

(ii) The Department does not pay a child care provider at another site if the "failed" provider is involved in the child care operation unless the Department determines that the reasons the provider is in "failed" status are not relevant to the new site.

(C) A provider with a status of "failed" may reapply at any time by providing the required documents and information to the Department for review.

(d) A finding of "suspended".

(A) A provider may be "suspended" if the Department determines and provides notice that the provider does not meet an eligibility requirement in the following subsections and paragraphs of section (7) of this rule: (b), (d), (e), (h), (i), (j), (k), (l), (p)(H), (p)(I), (p)(L), (u), or in section (10) of this rule. A provider who has been "suspended" may challenge this status by requesting a contested case hearing subject to the requirements and limitations of OAR 461-025.

(B) While the provider is in "suspended" status:

(i) The provider is ineligible for payment for at least six months.

(ii) The Department does not pay any other child care provider for child care at the "suspended" provider's site.

(iii) The Department does not pay a child care provider at another site if the "suspended" provider is involved in the child care operation

unless the Department determines that the reasons the provider is in "suspended" status are not relevant to the new site.

(C) A provider with a status of "suspended" may be eligible for payments after the six month ineligibility period ends when the provider has been approved following reapplication, including providing the required documents and information to the Department for review.

(e) The Department has referred an overpayment against the provider for collection and the claim is unsatisfied.

(4) The provider must submit a completed Child Care Provider Listing Form (DHS 7494) to the Department within 30 calendar days from the date the Department issues the listing form to the client. The provider and each *subject individual* must be enrolled in the *Central Background Registry* without condition or limitation as provided under OAR 414-061-0090. Any other *subject individual* must hold a conditional or limited enrollment as allowed under OAR 414-061-0000 through 414-061-0120.

(5) To receive payment or authorization for payment, the provider must comply with at least one of the following subsections:

(a) If the provider is not *legally exempt*:

(A) Be currently certified or registered with OCC under OAR 414-205-0000 to 414-205-0170, 414-300-0000 to 414-300-0440, 414-310-0100 to 414-310-0720, or 414-350-0000 to 414-350-0250 and be in compliance with the applicable rules;

(B) Complete the Department's listing process; and

(C) Be approved by the Department.

(b) If the provider is *legally exempt* and a *legally exempt relative* (see section (11) of this rule):

(A) Complete the *Central Background Registry* enrollment procedures under OAR 414-061-0090;

(B) Complete the Department's listing process; and

(C) Be approved by the Department.

(c) If the provider is *legally exempt* and not a *legally exempt relative* for all children in care:

(A) Meet all OCC Regulated Subsidy Provider requirements under OAR 414-180-0005 through 414-180-0100;

(B) Submit to and pass a site visit at the location where care will be provided;

(C) Complete the *Central Background Registry* enrollment procedures under OAR 414-061-0090;

(D) Complete the Department's listing process; and

(E) Be approved by the Department.

(d) In the case of a child care facility licensed by a sovereign tribal nation:

(A) Must receive annual health and safety inspections from the Indian Health Services;

(B) Each individual who may have unsupervised access to a child in care must be enrolled in the *Central Background Registry*;

(C) Complete the Department's listing process; and

(D) Be approved by the Department.

(6) Each provider and each *subject individual* must have a history of behavior that indicates no substantial risk to the health or safety of a *child* in the care of the provider.

(7) Each provider must:

(a) Obtain written approval from their certifier or certifier's supervisor if the provider is also certified as a foster parent.

(b) Be 18 years of age or older and meet all of the following:

(A) Be enrolled in and not suspended from the *Central Background Registry* or be in an approved status by the Department;

(B) Have competence, sound judgment and self-control when working with children; and

(C) Be mentally, physically and emotionally capable of performing duties related to child care.

(c) Not be in the same ERDC or TANF filing group (see OAR 461-110-0330 and 461-110-0350) as the *child* cared for; the *parent* (see OAR 461-001-0000) of a *child* in the *filing group*; or a sibling living in the home of the *child*.

(d) Allow the Department to visit or inspect the site of care while child care is provided.

(e) Keep and provide daily records as follows:

(A) Attendance records must accurately record the arrival and departure times for each *child* in care.

(B) Written attendance and billing records for each *child* receiving child care benefits from the Department must be retained for a minimum of 12 months.

(C) All records of attendance and billing must be provided to the Department upon request.

(D) Records for absent days billed to the Department under OAR 461-155-0150 must record the hours the *child* was scheduled to be in care and indicate the *child* was absent.

(f) Be the individual or facility listed as providing the child care.

(g) Only use someone else to supervise a *child* on a temporary basis if all of the following are met:

(A) The person was included on the most current listing form;

(B) The person is enrolled in the *Central Background Registry*; and

(C) The provider notifies the Direct Pay Unit (DPU).

(h) Not bill a Department client for an amount collected by the Department to recover an overpayment or an amount paid by the Department to a creditor of the provider because of a lien, garnishment, or other legal process.

(i) Report to DPU within five days of occurrence:

(A) Any arrest, indictment, or conviction of any *subject individual* or individual described in section (5) of this rule.

(B) Any involvement of any *subject individual* or individual described in section (5) of this rule with CPS; the Office of Training, Investigations and Safety (OTIS); or any other agencies providing child or adult protective services.

(C) Any change to the provider's name or address including any location where care is provided.

(D) The addition of any *subject individual*.

(E) Any reason the provider no longer meets the requirements under this rule.

(j) Report suspected child abuse of any *child* in the provider's care to the child abuse and neglect hotline or a law enforcement agency.

(k) Supervise each *child* in care at all times. This includes being within sight or sound of all children; being aware of what each child is doing; being near enough to children to respond when needed; and being physically present when kindergarten-age or younger children are playing outside, unless the play area is fully fenced and hazard free.

(l) Prevent any individual who behaves in a manner that may harm children from having access to a *child* in the care of the provider. This includes anyone *under the influence* (see section (12) of this rule).

(m) Allow the custodial parent of a *child* in the provider's care to have immediate access to the *child* at all times.

(n) Inform a parent of the need to obtain immunizations for a *child* and have a completed, up-to-date Oregon shot record called the "Certification of Immunization Status" (CIS) form, or a non-medical or medical Exemption form, on file for each *child* in care.

(o) Take reasonable steps to protect a *child* in the provider's care from the spread of infectious diseases.

(p) Ensure that the home or facility where care is provided meets all of the following standards:

(A) Each floor level used by a *child* has two usable exits to the outdoors (a sliding door or window that can be used to evacuate a *child* is considered a usable exit). If a second floor is used for child care, the provider must have a written plan for evacuating occupants in the event of an emergency.

(B) The home or facility has water that is safe for drinking and preparing food (see section (14) of this rule).

(C) The home or facility has a working smoke detector on each floor level and in any area where a *child* naps.

(D) Each fireplace, space heater, electrical outlet, wood stove, stairway, pool, pond, and any other hazard has a barrier to protect a *child*. Any gate or barrier may not pose a risk or hazard to any *child* in care.

(E) Any firearm, ammunition, and other items that may be dangerous to children, including but not limited to alcohol, inhalants, tobacco and e-cigarette products, matches and lighters, any legally prescribed or over-the-counter medicine, cleaning supplies, paint, plastic bags, and poisonous and toxic materials are kept in a secure place out of a child's reach.

(F) The building, grounds, any toy, equipment, and furniture are maintained in a clean, sanitary, and hazard-free condition.

(G) The home or facility has a telephone in operating condition.

(H) No one may smoke or carry any lighted smoking instrument, including e-cigarettes or vaporizers, in the home or facility or within ten feet of any entrance, exit, window that opens, or any ventilation intake that serves an enclosed area, during child care operational hours or anytime child care children are present. No one may use smokeless tobacco in the home or facility during child care operational hours or anytime child care children are present. No one may smoke or carry any lighted smoking instrument, including e-cigarettes and vaporizers, or use smokeless tobacco in motor vehicles while child care children are passengers.

(I) No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) on the *premises* (see section (12) of this rule) during child care operational hours or anytime child care children are present. No one *under the influence* of alcohol, controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) may be on the *premises* during child care operational hours or anytime child care children are present. No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) in motor vehicles while child care children are passengers.

(J) Is not a half-way house, hotel, motel, shelter, or other temporary housing such as a tent, trailer, or motor home. The restriction in this paragraph does not apply to licensed (registered or certified) care approved in a hotel, motel, or shelter.

(K) Is not a structure –

(i) Designed to be transportable; and

(ii) Not attached to the ground, another structure, or to any utilities system on the same *premises*.

(L) Controlled substances (except lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana, marijuana edibles, and other products containing marijuana), marijuana plants, derivatives, and associated paraphernalia may not be on the premises during child care operational hours or anytime child care children are present.

(q) Complete and submit a new listing form every two years, or sooner at the request of the Department, so that the Department may review the provider's eligibility.

(r) Provide evidence of compliance with the Department's administrative rules, upon request of Department staff.

(s) Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety, and crib standards under 16 CFR 1219 and 1220.

(t) Place infants to sleep on their backs.

(u) Not hold a medical marijuana card; or distribute, grow, or use marijuana (including medical marijuana) or any controlled substance (except lawfully prescribed and over-the-counter medications).

(v) Develop and communicate expulsion and suspension policies to parents and caretakers.

(w) Provide care at a location within the state of Oregon.

(8) *Legally exempt* providers must complete the "Introduction to Child Care Health and Safety" two-hour, web-based training prior to Department approval.

(9) *Legally exempt* providers must complete the two part orientation provided by the Department or a Child Care Resource and Referral agency within 90 days of being approved by the Department if the provider begins providing child care services after June 30, 2010, or resumes providing child care services, after a break of more than one year that began after June 30, 2010.

(10) Child care providers and any individual supervising, transporting, preparing meals, or otherwise working in the proximity of child care children and those completing daily attendance and billing records shall not be *under the influence*.

(11) For purposes of these rules:

(a) "Premises" means the home or facility structure and grounds, including indoors and outdoors and space not directly used for child care.

(b) "Under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the individual has used alcohol, any controlled substances (including lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana), or inhalants that impairs their performance of essential job function or creates a direct threat to child care children or others. Examples of abnormal behaviors include, but are not limited to hallucinations, paranoia, or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech as well as difficulty walking or performing job activities.

(c) "Legally exempt" means the child care provider is exempt from licensing with the OCC because the provider is not subject to the licensing requirements under OAR 414-205-0000 to 414-205-0170, OAR 414-350-000 to 414-350-0405, and OAR 414-300-0000 to 414-300-0415.

(d) "Legally exempt relative" means a *legally exempt* provider who is a relative to all children in care including a great-grandparent, grandparent, aunt, uncle, or sibling not living in the home of any *child* in care.

(12) *Legally exempt* providers that are not a *legally exempt relative* to all children in care must meet all of the requirements in this section:

(a) Before approval by the Department:

(A) Have an up-to-date, in-person infant and child CPR and first aid certification or have a currently valid waiver of this requirement from the Child Care Resource and Referral program.

(B) Complete the Recognizing and Reporting Child Abuse and Neglect (RRCAN) web-based or classroom training.

(b) After approval by the Department:

(A) Complete six hours of ongoing education in each two-year listing period as provided in this subsection. All trainings must be accepted by the Oregon Center for Career Development (OCCD) and be part of the OCCD’s 10 Core Knowledge Categories recognized by Oregon Registry Online to count toward the six hours.

(i) Two of the six hours must fall under the "Human Growth and Development" category; and

(ii) Two of the six hours must cover "Understanding & Guiding Behavior".

(B) Complete a Health and Safety training offered by OCCD annually.

(C) Complete the Child Development training offered by OCCD, as follows:

(i) Providers approved on or after October 1, 2022 must complete the training within 90 days of ODHS approval.

(ii) Providers approved before October 1, 2022 must complete the training by December 31, 2022 to remain approved.

(13) Child care centers or programs that are *legally exempt* from certification or registration with OCC, are located in a commercial or institutional facility, and receive payment from the Department on behalf of a family receiving a child care subsidy, must comply with the following minimum staff to children in care ratios:

(a) Six weeks through 23 months of age, the minimum number of staff to children is one to four. The maximum number of children in a group is eight.

(b) 24 months through 35 months of age, the minimum number of staff to children is one to five. The maximum number of children in a group is 10.

(c) 36 months of age to attending kindergarten, minimum number of staff to children is one to 10. The maximum number of children in a group is 20.

(d) Attending kindergarten and older, the minimum number of staff to children is one to 15. The maximum number of children in a group is 30.

(e) In a mixed-age group of children, the number of staff and group size shall be determined by the age of the youngest child in the group.

(14) Except as noted otherwise below, the requirements of this section are in effect starting September 30, 2018. As used in this section, "drinking water faucet or fixture" means any plumbing fixture on the premises used to obtain water for drinking, cooking, preparing infant formula or preparing food. This section only applies to a provider who is *legally exempt* and not a *legally exempt relative*. This section applies to *legally exempt* providers approved to receive Department subsidy payments prior to September 30, 2018. This section applies to *legally exempt* providers who submit a completed Child Care Provider Listing form for Department-approval starting September 30, 2018. This section does not apply to care provided in the child's home when the *legally exempt* provider lives somewhere else.

(a) In locations where care is provided, lead testing is required for each *drinking water faucet or fixture*.

(b) Providers must test each *drinking water faucet or fixture* at least once every six years from the date of the last test. Providers who have had a *drinking water faucets or fixture* tested within six years prior to the effective date of this rule will need to submit the results to OCC.

(c) If a home or facility does not use any of the on-site plumbing fixtures to obtain water for drinking, cooking, preparing infant formula, or preparing food, the provider must:

(A) Submit a written statement to the Department or OCC identifying the alternative source of water and confirming that the provider does not use any on-site plumbing fixtures for drinking, cooking, preparing infant formula, or preparing food; and

(B) Notify the Department or OCC in writing if the alternative source of water changes.

(d) All sample collection and testing must be in accordance with the Environmental Protection Agency (EPA)'s 3Ts for Reducing Lead in Drinking Water in Schools and Child Care Facilities, Revised Manual from October 2018, adopted by this reference.

(A) If test results show water from any *drinking water faucet or fixture* has 15 parts per billion (ppb) or more of lead, the provider must:

(i) Prevent access to that *drinking water faucet or fixture* immediately after receiving the test results; and

(ii) Continue to prevent access to that *drinking water faucet or fixture* until mitigation is completed in accordance with paragraph (B) of this subsection.

(B) Following receipt of test results showing that water from any *drinking water faucet or fixture* has 15 parts per billion (ppb) or more of lead, the provider must comply with all of the following sub-paragraphs:

(i) Submit a corrective action plan to the Department or OCC for approval within 60 days of receiving the test results. The corrective action plan must identify an appropriate mitigation strategy in accordance with Module 6 of the EPA's 3Ts for Reducing Lead in Drinking Water in Schools and Child Care Facilities, Revised Manual from October 2018, adopted by this reference.

(ii) Implement the mitigation method within 30 days of approval by OCC.

(C) A provider who fails to submit a corrective action or a mitigation method is no longer eligible to receive child care subsidy payments.

(e) The provider must keep a copy of the most recent test results on-site at all times.

(f) Providers must follow the routine practices identified in Module 6 of the EPA's 3Ts for Reducing Lead in Drinking Water in Schools and Child Care Facilities, Revised Manual from October 2018.

(15) A child care provider approved to receive payment may become retroactively ineligible for payment starting on the date the provider violates a requirement under this rule, regardless of the date of the finding.

(16) The Oregon Department of Human Services Background Check Unit (BCU) shall retain their authority to determine eligibility for any child care providers whose applications, including incomplete applications, were submitted before September 1, 2022.]

Statutory/Other Authority: ORS 181.537, 329A.500, 409.050, 411.060, 411.070
Statutes/Other Implemented: ORS 181.537, 329A.340, 329A.500, 409.010, 409.050, 409.610, 411.060, 411.070, 411.122, 45 CFR 98.44, HB 4005 Oregon 2022 Short Sess.

461-165-0410 Eff. ~~11-1-16~~07/01/23
Provider Listing; Disqualifying Criminal History

THIS RULE IS REPEALED

[(1) This rule explains the grounds upon which the Department denies a request by a child care provider to receive child care payments from a self-sufficiency program of the Department based on the records of a *subject individual* (see OAR 125-007-0210 and 407-007-0210(8)(a)(J)). For the purposes of this rule, the provider and any individual identified under OAR 461-165-0180(4) is considered a *subject individual* under OAR 125-007-0210 and 407-007-0210(8)(a)(J).

(2) The Department may find a child care provider ineligible for payment when the criminal history of a *subject individual* indicates behavior that may jeopardize the safety of a child or have a detrimental effect on a child while in the care of the provider, in the following circumstances, the *subject individual* has:

(a) Been charged with or arrested for a drug-related, sexual, or violent crime listed in OAR 407-007-0270(1). There is a rebuttable presumption that such a *subject individual* is likely to engage in conduct that would pose a significant risk to a client, the Department, or a vulnerable individual.

(b) Been convicted of two or more crimes listed in OAR 125-007-0270 at any time.

(c) Been found in violation of probation for a crime listed in OAR 125-007-0270, at any time that relates to the person's qualification or duties as a child care provider.

(d) Been charged with two or more crimes listed in OAR 125-007-0270 within the past five years.

(e) Three or more arrests, at any time, for crimes listed in OAR 125-007-0270.

(3) The Department may pay for the services of a child care provider even if a *subject individual* has a potentially disqualifying criminal or abuse history, defined by OAR 125-007-0270 and 407-007-0290, only if the Department has determined -- based on a weighing test as described in OAR 125-007-0260, 407-007-0300, and 407-007-0320 and consideration of the information listed in OAR 407-007-0280, 407-007-0290, and this rule -- that repeated criminal behavior is unlikely and that the provider does not present a danger to a child in the provider's care.]

Stat. Auth.: ORS 181.537, 411.060
Stats. Implemented: ORS 181.537, 411.060, 411.122

461-165-0420 Eff. ~~11-1-16~~07/01/23

Provider Listing; Disqualifying Child Protective Service History

THIS RULE IS REPEALED

[(1) This rule explains the grounds upon which the Department denies the request by a child care provider to receive child care payments from a self-sufficiency program of the Department based on the records of a *subject individual* (see OAR 125-007-0210 and 407-007-0210(8)(a)(J)). For the purposes of this rule, the provider and any individual identified under OAR 461-165-0180(4) is considered a *subject individual* under OAR 125-007-0210 and 407-007-0210(8)(a)(J).

(2) The Department may find a child care provider ineligible for payment when the Child Protective Service (CPS) history of a *subject individual,* based on prior conduct, indicates that a *subject individual* is likely to engage in conduct that would jeopardize the safety of or have a detrimental effect on a child while in the care of the provider.

(3) To make its determination, the Department may use any available information including the CPS records of the Department, an investigation of a complaint, or information provided by another agency. A single incident may be sufficient history for denial of eligibility.

(4) If the Department obtains information of a potentially disqualifying nature with respect to a *subject individual*, as described in OAR 461-165-0180(4), the Department may request additional information to determine the provider's ability to provide care and must conduct a weighing test under OAR 125-007-0260, 407-007-0300, and 407-007-0320. Any additional information obtained must be reviewed by the Criminal Records Unit (CRU) for determination of eligibility.

(5) Failure to respond to a request for information results in a finding of "failed" (see OAR 461-165-0180). The provider or *subject individual* must disclose fully all requested information as part of the records check.

(6) The Department may pay for the services of a child care provider even if a *subject individual* has a potentially disqualifying history of behavior if the Department determines, based on a fitness determination made under OAR 125-007-0260 and 407-007-0320, that repeated behavior is unlikely and that the presence of the individual likely would not jeopardize the safety of a child in the provider's care based on:

(a) The content and source of the reports, the time elapsed since the reports, and the number of reports and referrals;

(b) The individual's participation in rehabilitation, training, or counseling;

(c) The likelihood of the individual's abuse of drugs or alcohol; and

(d) Any other relevant eligibility requirements or supplemental information under OAR 407-007-0300 or OAR 461-165-0180.]

Stat. Auth.: ORS 409.027, 409.050, 411.060
Stats. Implemented: ORS 409.010, 409.027, 411.060

461-165-0430 Eff. ~~1-1-~~
~~18~~07/01/23
Child Care Provider Hearings

THIS RULE IS REPEALED

[(1) A child care provider has a right to a contested case hearing only to contest a fitness determination that results in a denial of eligibility for payment, dispute an allegation of an overpayment of child care, or dispute a finding of suspended. Hearings to contest a fitness determination that results in a denial are governed by OAR 407-007-0330. Other hearings under this section are governed by division 461-025 of the Oregon Administrative Rules.

(2) In the case of an alleged overpayment, the child care provider may delay repayment on an overpayment until a final order is served by completing a request for hearing not later than the 45th day following the date of the overpayment notice.

(3) A child care provider whose application for listing is denied and who fails to request a hearing within the 45-day hearing request period is not eligible to reapply for listing until 180 days following the date of the denial notice.

(4) If a child care provider requests a hearing to contest a fitness determination resulting in a denial of eligibility for payment, the child care provider remains ineligible for payment pending the hearing unless the decision to deny eligibility was based on a mistake in identifying the person with the CH or CPS record.]

Stat. Auth.: ORS 181.537, 329A.500, 409.050, 411.060
Stats. Implemented: ORS 181.537, 329A.500, 409.010, 411.060, 411.095

461-170-0150 Eff. ~~12-1-18~~7/01/23

THIS RULE IS REPEALED

[Certification Period; ERDC

In the ERDC program:

(1) The length of the *certification period* (see OAR 461-001-0000) may not be less than 12 months. In the following situations the *certification period* may be extended beyond the certification end date:

(a) Caretakers in authorized work search and medical leave are limited to no more than three additional months.

(b) Caretakers on military transition are limited to no more than six additional months.

(c) Caretakers who have entered into a contracted slot with Head Start, Early Head Start or the Early Head Start Child Care Partnership program are limited to no more than eleven additional months.

(2) A filing group (see OAR 461-110-0310 and 461-110-0350) that is determined to be *homeless* (see OAR 461-001-0000) or requires child care for a current foster child may receive "priority processing." For purposes of this rule, "priority processing" means the benefits may be open for up to three months while pending for verification of income, work schedule, verification of immunization records, or a copy of the medical or non-medical exemption form (see OAR 461-135-0400) during the application period.]

Stat. Auth.: ORS 329A.500, 409.050, 411.060
Stats. Implemented: ORS 329A.500, 409.010, 409.610, 411.060, 45 CFR 98.41

461-170-0160 Eff. ~~1-1-~~
~~16~~7/01/23
When a Reapplication Form is Considered Complete or Not Received; ERDC

THIS RULE IS REPEALED

[In the ERDC program:

(1) At the end of the certification, authorized work search, medical leave, or military transition period (see OAR 461-160-0040(5)), whichever is later, a client must complete and return to a Department *branch office* (see OAR 461-001-0000) a reapplication form before a new *certification period* may be established under OAR 461-170-0150.

(2) A reapplication form is considered complete when it is received by a Department *branch office* by the 10th day of the last month of the certification, authorized work search, medical leave, or military transition period, whichever is later, and:

(a) The client answers, completely and accurately, all questions necessary to determine a copay amount for the following *certification period*;

(b) The client provides all required verification; and

(c) The form contains the signature of the *primary person* (see OAR 461-001-0000) or the *authorized representative* (see OAR 461-115-0090).

(3) When a Department *branch office* receives a completed reapplication form by the deadline in section (2) of this rule, the form is used to:

(a) Determine *eligibility* (see OAR 461-001-0000) for ERDC benefits;

(b) Establish the ERDC benefit copay amount for the next *certification period*; and

(c) Establish the next *certification period* as beginning on the first day of the month following the last month of the previous certification, authorized work search, medical leave, or military transition period, whichever is later.

(4) When a Department *branch office* does not receive a completed reapplication form on or before the deadline in section (2) of this rule, the case is closed effective the last day of the last month of the certification, authorized work search, medical leave, or military transition period, whichever is later.

(5) If the reapplication form is received after the deadline in section (2) of this rule, it is treated as a new application in accordance with OAR 461-115-0050.]

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 409.610, 411.060, 411.105, 411.111

461-175-0207 Eff. ~~4-1-03~~07/01/23
Notice Situation; Child Care Benefit Calculation

THIS RULE IS REPEALED

[For decisions concerning ERDC or TANF child care benefits, the Department sends a continuing benefit decision notice when benefits are calculated in accordance with OAR 461-155-0150.]

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060

461-180-0005 Eff. ~~10-1-09~~7/01/23

THIS RULE IS REPEALED

[Effective Dates; Acting on Changes; ERDC

In the ERDC program:

(1) For changes reported on the reapplication form, the effective date is:

(a) The first day of the next *certification period* (see OAR 461-001-0000); or

(b) If changes will end benefits, the last day of the current *certification period*.

(2) For changes not reported on the reapplication form:

(a) For changes that require the *certification period* to be shortened, the effective date for the end of the *certification period* becomes the last day of the month in which the notice period ends. If the notice period ends the month after the change is reported, and the information results in an increase in benefits, adjust benefits for the last month of the shortened *certification period*.

(b) For all other changes that will cause:

(A) An increase in benefits, the effective date is the first of the month after the *filing group* (see OAR 461-110-0350) reports the change.

(B) A decrease in benefits, the effective date is the first of the month after the notice period ends.

(c) For changes that will end benefits, the effective date is the last day of the month in which the notice period ends.]

Stat. Auth.: 411.060, 411.070
Stats. Implemented: 411.060, 411.070

461-150-0060 Eff. ~~9/27/22~~07/01/23

Prospective or Retrospective Eligibility and Budgeting; ~~ERDC,~~ REF, REFM, SNAP, TANF

In the ~~ERDC,~~ REF, REFM, SNAP, and TANF programs, the Department determines how and when to use prospective or retrospective *eligibility* (see OAR 461-001-0000) and *budgeting* (see OAR 461-001-0000) as follows:

(1) For the *initial month* (see OAR 461-001-0000):

~~(a) In the ERDC program, income is budgeted so the anticipated amount is the same for each month, including the *initial month*.~~

(a~~b~~) For a SNAP case in CRS, the Department uses "actual income" (see subsection (g~~h~~) of this section) in the *initial month*.

(b~~e~~) For a SNAP program case in SRS, "actual income" is used in the *initial month* if that income is not reflective of ongoing monthly income due to a new or terminated source or a significant change in ongoing income. All other income is processed under section (3) of this rule.

(c~~d~~) In the REF and TANF programs, ongoing income, processed under section (2) of this rule, is used in the *initial month*, except when the source of income is a new or terminated source. When there is a new or terminated source of income, "actual income" is used in the *initial month*.

(d~~e~~) In the REFM program, the Department uses only the *initial month* for *eligibility* and *budgeting*.

(e~~f~~) The Department uses prospective *eligibility* and *budgeting* under OAR 461-150-0020 for cases not covered under subsections (a) to (d~~e~~) of this section, including for an individual who leaves a filing group (see OAR 461-110-0310) because of *domestic violence* (see OAR 461-001-0000) and enters a *domestic violence shelter* (see OAR 461-001-0000) or *safe home* (see OAR 461-001-0000).

(f~~g~~) No supplement is issued based on incorrectly anticipated information.

(g~~h~~) "Actual income" means income already received in the *initial month* plus all the income that reasonably may be expected to be received within the *initial month*.

(2) Income is budgeted so that the anticipated amount is the same for each month. The type of income is determined and calculated as follows:

(a) Income that must be annualized is calculated under OAR 461-150-0090 to arrive at a monthly figure.

(b) Educational income (see OAR 461-145-0150) is assigned to the months it is intended to cover, regardless of when it is received. The income is prorated over these months.

(c) Ongoing *stable income* (see OAR 461-001-0000) is anticipated under OAR 461-150-0070.

(d) Ongoing *variable income* (see OAR 461-001-0000) is anticipated under OAR 461-150-0080.

(e) *Periodic income* (see OAR 461-001-0000) is anticipated under OAR 461-140-0110.

(f) *Lump-sum income* (see OAR 461-001-0000) is anticipated under OAR 461-140-0120.

(3) For an *ongoing month* (see OAR 461-001-0000):

(a) For a *benefit group* (see OAR 461-110-0750), the Department uses prospective *eligibility* and *budgeting*. The type of income is determined and calculated under section (2) of this rule.

(b) If the *budgeting* method changes from prospective to retrospective, the Department treats income from a terminated source that was counted prospectively as follows:

(A) If the actual amount received was less than or equal to the anticipated amount, the income is excluded.

(B) If the actual amount received was greater than the anticipated amount, the Department counts the difference between actual and anticipated amounts.

(4) When an individual is added to an ongoing filing group, income is budgeted in accordance with sections (2) and (3) of this rule to determine *eligibility* and benefit level.

(5) In the SNAP program during the Periodic Report Process, the Department follows the budgeting provisions of sections (2) through (4) of this rule to determine *eligibility* and benefit level using all of the following:

(a) Income recently verified and currently budgeted for the case that does not meet the provisions of or conflict with income in subsections (b) or (c).

(b) Income from computer matches.

(c) Total income reported on the Periodic Report form under OAR 461-170-0011 and 461-170-0102 –

(A) Whose verification is provided with the Periodic Report.

(B) That, in comparison to the total *countable* (see OAR 461-001-0000) earned income already budgeted for the *financial group* (see OAR 461-110-0530) has changed by more than $125.

(C) That, in comparison to the total *countable* unearned income already budgeted for the *financial group,* has changed by more than $125.

(D) That exceeds the SNAP Countable Income Limit set at 130 percent of the federal poverty level under OAR 461-155-0180, for a *financial group* whose *eligibility* was based on total *countable* income at or below 130 percent.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.049
Statutes/Other Implemented: ORS 409.010, 409.050, 409.610, 411.060, 411.070, 411.404, 411.816, 412.049

461-150-0090 Eff. ~~1-1-16~~07/01/23

Prospective Budgeting: Annualizing and Prorating Contracted or Self-employment Income; Not OSIP, OSIPM, or QMB

(1) Income from self-employment, including contract income while self-employed, is treated in accordance with OAR 461-145-0910 unless the income meets the provisions of section (2) of this rule.

(2) If past contract income is not representative of future income or when a substantial increase or decrease is expected in *countable* (see OAR 461-001-0000) self-employment income (see OAR 461-145-0910) in the next year, costs as allowed under OAR 461-145-0930 and anticipated income are used to determine the *countable* income.

(3) In the ~~ERDC,~~ REF, SNAP, and TANF programs, contract income that does not meet the criteria of self-employment income (see OAR 461-145-0910) is treated as follows:

(a) Income received during a less than 12-month period but intended as a full year's income is annualized.

(b) Income received on an hourly or piecework basis or monthly over the term of the contract period is not annualized. It is treated as *stable income* (see OAR 461-001-0000) under OAR 461-150-0070 or *variable income* (see OAR 461-001-0000) under OAR 461-150-0080.

(4) In the REFM program, contract income that does not meet the criteria of self-employment income (see OAR 461-145-0910) is treated as follows:

(a) Income is counted only if received in the month of application. If income counted in the month of application puts the applicant over the income limits for REFM, the income is annualized.

(b) Income received on an hourly or piecework basis or monthly over the term of the contract period is not annualized. It is treated as *stable income* (see OAR 461-001-0000) under OAR 461-150-0070 or *variable income* (see OAR 461-001-0000) under OAR 461-150-0080.

(5) Contract income that is not the annual income of the *financial group* (see OAR 461-110-0530) and not paid on an hourly or piecework basis is prorated over the period the income is intended to cover.

Statutory/Other Authority~~. Auth.~~: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049

Statutes/Other~~s.~~ Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049

(1) A Department program may cite this rule if the program uses a monthly income standard based on the federal poverty level ~~or state median income~~.

(2) A monthly income standard set at 100 percent of the 2022 federal poverty level, and updated every October, is set at the following amounts:

Size of Group	Standard
1	$ 1,133
2	1,526
3	1,920
4	2,313
5	2,706
6	3,100
7	3,493
8	3,886
9	4,280
10	4,674
+1	+394

(3) A monthly income standard set at 130 percent of the 2022 federal poverty level, and updated every October is set at the following amounts:

Size of Group	Standard
1	$ 1,473
2	1,984
3	2,495
4	3,007
5	3,518
6	4,029
7	4,541
8	5,052
9	5,564
10	6,076
+1	+512

(4) A monthly income standard set at 165 percent of the 2022 federal poverty level, and updated every October, is set at the following amounts:

Size of Group	Standard
1	$ 1,869
2	2,518
3	3,167

4…… 3,816
5…… 4,465
6…… 5,114
7…… 5,763
8…… 6,412
+1……... +649

(5) A monthly income standard set at 185 percent of the 2023 federal poverty level, and updated every March, is set at the following amounts:

Size of Group……Standard
1……$ 2,248
2…… 3,041
3…… 3,833
4…… 4,625
5…… 5,418
6…… 6,210
7…… 7,003
8…… 7,795
9…… 8,588
10…….. 9,381
+1……... + 793

(6) A monthly income standard set at 200 percent of the 2023 federal poverty level, and updated every March, is set at the following amounts:

Size of Group……Standard
1……$ 2,430
2…… 3,287
3…… 4,144
4…… 5,000
5…… 5,857
6…… 6,714
7…… 7,570
8…… 8,427
+1……... + 857

(7) A monthly income standard set at 250 percent of the 2023 federal poverty level, and updated every March, is set at the following amounts:

Size of Group……Standard
1……$ 3,038
2…… 4,109

3…… 5,180
4…… 6,250
5…… 7,321
6…… 8,392
7…… 9,463
8…… 10,534
+1…… +1,071

(8) A monthly income standard set at 350 percent of the 2023 federal poverty level, and updated every March beginning 2023, is set at the following amounts:

Size of Group……Standard
1……$ 4,253
2…… 5,752
3…… 7,251
4…… 8,750
5…… 10,250
6…… 11,749
7…… 13,248
8…… 14,747
9…… 16,247
10…….. 17,745
+1……... + 1,500

~~(9) A monthly income standard set at 85 percent of the 2023 state median income, and updated every March, is set at the following amounts:~~

~~Size of Group……Standard~~
~~2……$ 4,827~~
~~3…… 5,963~~
~~4…… 7,099~~
~~5…… 8,234~~
~~6…… 9,370~~
~~7…… 9,583~~
~~8…… 9,796~~

(9~~10~~) A monthly Disaster Supplemental Nutrition Assistance Program (DSNAP) income standard, updated every October, is set at the following amounts for the *household* (see OAR 461-135-0491):

Size of Group……Standard
1……$ 1,950
2…… 2,343

3……	2,737
4……	3,130
5……	3,555
6……	3,982
7……	4,375
8……	4,768
+1……...	+394

Statutory/Other Authority: ORS ~~329A.500,~~ 409.050, 411.060, 411.070, 411.816, 412.014, 412.049
Statutes/Other Implemented: ORS ~~329A.500,~~ 409.010, 411.060, 411.070, 411.816, 412.014, 412.049, 7 CFR 280.1

461-160-0010 Eff. ~~4/01/20~~07/01/23

Use of Resources in Determining Financial Eligibility

Countable (see OAR 461-001-0000) resources are used to determine *eligibility* (see OAR 461-001-0000) as follows:

(1) In the EA program, the *countable* resources of a *financial group* (see OAR 461-110-0530) are used to reduce benefits.

(2) In the ~~ERDC,~~ QMB-DW, REF, REFM, and TANF programs, a *need group* (see OAR 461-110-0630) is not eligible for benefits if the *financial group* has *countable* resources above the resource limit (see OAR 461-160-0015).

(3) In the SNAP program, unless *categorically eligible* (see OAR 461-135-0505), a *need group* is not eligible for benefits if the *financial group* has *countable* resources above the resource limit (see OAR 461-160-0015).

(4) In the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs:

(a) An individual is not eligible for benefits if the *financial group* has *countable* resources above the resource limit (see OAR 461-160-0015).

(b) The following provisions apply when a *child* (see OAR 461-001-0000) who is not *assumed eligible* (see OAR 461-135-0010) is applying:

(A) As used in the subsection, “ineligible parent” means a *parent* (see OAR 461-001-0000) who is not receiving SSI or TANF.

(B) As used in this section, "parental resources" means the *countable* resources of:

(i) Each *ineligible parent* (see paragraph (A) of this subsection) in the *financial group* of the *child*; and

(ii) Each *spouse* (see OAR 461-001-0000) of an *ineligible parent* in the *financial group* of the *child*.

(C) The *parental resources* (see paragraph (B) of this subsection) are deemed available to the *child*. The amount deemed available to the *child* is the amount the *parental resources* exceed the resource limit (see OAR 461-160-0015) of:

(i) A one-person *need group*, if one *parent* (see OAR 461-001-0000) lives in the household of the *child*; or

(ii) A two-person *need group*, if two parents (or one *parent* and the *spouse* (see OAR 461-001-0000) of that parent) live in the household of the *child*.

(D) If more than one *child* is applying, the value of the deemed resources is divided evenly between the applying children. If an applying *child* is determined to be ineligible for OSIPM for any reason including excess resources resulting from deeming, no resources are deemed to that *child*. Any resources deemed to an applying *child* determined to be ineligible for OSIPM are deemed equally to other applying children.

(E) The *parental resources* are not deemed available to a non-applying *child*.

(F) The value of the *parental resources* is subject to deeming whether or not those resources are available to the *child*.

(5) In the OSIP-EPD and OSIPM-EPD programs:

(a) A *need group* is not eligible for benefits if the *financial group* has *countable* resources above the resource limit (see OAR 461-160-0015).

(b) Any money in an *approved account* (see OAR 461-001-0035) is excluded during the determination of *eligibility*.

(c) Assets purchased from moneys in an *approved account* are excluded, provided they meet the requirements of OAR 461-145-0025.

(d) Assets purchased as *employment and independence expenses* (see OAR 461-001-0035) are excluded, provided they meet the requirements of OAR 461-145-0025.

(6) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, all resources are excluded and have no effect on *eligibility* (see OAR 461-160-0015).

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.117, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685, 414.839

(1) In the EA program, all *countable* (see OAR 461-001-0000) resources must be used to meet the emergent need.

~~(2) In the ERDC program, the limit is $1,000,000.~~

(23) In the OSIP and OSIPM programs, the resource limit is as follows:

(a) $2,000 for a one-person *need group* (see OAR 461-110-0630) and $3,000 for a two-person *need group*.

(b) $5,000 for the OSIP-EPD and OSIPM-EPD programs (see OAR 461-001-0035 and 461-145-0025 for funds that may be excluded as approved accounts).

(34) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, all resources are excluded.

(45) In the QMB-DW program, the resource limit is $4,000 for a one-person *need group* and $6,000 for a *need group* containing two or more individuals.

(56) In the REF and REFM programs, the resource limit is:

(a) $2,500 for any of the following:

(A) A new REF or REFM applicant for benefits.

(B) In the REF program, the *need group* that has at least one *mandatory* (see OAR 461-130-0305) participant in an employment program who is:

(i) Receiving REF and not progressing in a required activity of an open case plan; or

(ii) Serving a current employment program disqualification (see OAR 461-130-0330).

(b) $10,000 for an REF *need group* not covered under subsection (a) of this section.

(67) In the SNAP program, unless *categorically eligible* (see OAR 461-135-0505), the resource limit is:

(a) $4,250 for a *financial group* (see OAR 461-110-0530) with at least one member who is *elderly* (see OAR 461-001-0015) or an individual with a *disability* (see OAR 461-001-0015).

(b) $2,750 for all other financial groups.

(78) In the TANF program, the resource limit is $10,000.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.083, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 409.010, 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.816, 411.837, 412.049, 413.085, 414.685, 414.839, HB 5202 Oregon 2022 Sess.

In the SNAP program:

(1) ~~In the SNAP program, d~~Dependent care is deductible (see OAR 461-160-0430) when all of the following are true:

(a) The dependent is a member of the filing group (see OAR 461-110-0310) and is in the care, control, and custody of an individual in the group.

(b) The dependent care provider--

(A) Is not in the filing group; and

(B) Is not the *parent* (see OAR 461-001-0000) of the dependent.

(c) The dependent care is necessary because the *caretaker* (see 461-001-0000) is working, commuting, on a meal break, in training, participating in pre-employment education, or participating in an OFSET *case plan* (see OAR 461-001-0020).

(2) ~~In the SNAP program, d~~Dependent care costs that are deductible under section (1) of this rule include:

(a) The costs of care provided by an individual care provider or care facility,

(b) Transportation costs to and from the individual care provider or care facility, and

(c) Activity or other fees associated with the care provided to the dependent that are necessary for the dependent to participate in the care; with the exception of fees related to penalties, fines, or advance payment for cost of care.

~~(d)~~

~~(e) (3) In the ERDC and TANF programs, the cost of dependent child care may be paid for by the Department (is covered) when dependent child care is necessary for the *caretaker* to perform the *caretaker*'s job duties, and in the ERDC program as indicated in subsection (c) of this section.~~

~~(f)~~

~~(g) (a) For a *caretaker* working under a JOBS Plus agreement, child care is covered during the time the *caretaker* is engaged in work or in job search.~~

~~(h)~~

~~(i) (b) Child care is covered for a *caretaker* participating in the Occupational Training and Child Care program who have applied for the program and actively engaged in training as outlined in the Occupational Training and Child Care program.~~

~~(j)~~

~~(k) (c) In the ERDC Program the cost of dependent care is also allowed for education hours, study hours, and for child care authorized under sections (6) and (7) of this rule; as follows:~~

(l)

(m) (A) When the allowable child care need totals 20 or fewer weekly hours of dependent child care, the cost of 20 weekly hours is allowed.

(n)

(o) (B) When the allowable child care need totals more than 20 but no more than 40 weekly hours of dependent child care, the cost of 40 weekly hours is allowed.

(p)

(q) (C) When the allowable child care need totals more than 40 weekly hours, the cost of the needed hours is allowed, up to 75 weekly hours.

(r)

(s) (D) In addition to the weekly hours allowed in paragraphs (A), (B), and (C) above, study hours will be allowed as follows:

(t)

(u) (i) 5 weekly hours for a *caretaker* who spends less than 12 hours a week in education settings.

(v)

(w) (ii) 10 weekly hours for a *caretaker* who spends 12 or more hours a week in education settings.

(4) In the ERDC, JOBS, and TANF programs, the cost of dependent child care is not covered by the Department when free care is available, such as during school hours for school-age children, unless a child is not attending in-person schooling and is instead participating in distance learning.

(5) Child care is not covered in the ERDC and TANF programs if the nature of the work of the *caretaker* does not make it necessary for a person other than the *caretaker* to provide the care. Child care is not covered during a period of time when --

(a) The nature of the work allows the *caretaker* to provide the care without significantly affecting the work;

(b) The *caretaker* provides child care in a residence; or

(c) The *caretaker* works for a provider of child care in a residence, unless the provider is a certified family child care home under OAR 414-350-0000 to 414-350-0400.

(6) In the ERDC program the cost of dependent child care may continue to be paid for by the Department (is covered) during the *certification period* (see OAR 461-001-0000) with no change to the authorized child care hours subject to the following provisions:

(a) When a reduction in work hours occurs the copay may be adjusted.

(b) When a job loss occurs:

(A) When a *caretaker* has a permanent job loss from all employment the copay is waived for up to three months for a work search period, starting the month after the job loss occurred.

(B) The waiver ends at the end of the three month period if the *caretaker* becomes employed.

(C) The three month work search period does not apply when:

(i) The adult was discharged or fired without *good cause* (see OAR 461-135-0070(2)) for misconduct, felony, or theft. "Misconduct" means willful or wantonly negligent violation of the standards of behavior which an employer has the right to expect of an employee, including an act or series of actions that amount to a willful or wantonly negligent disregard of an employer's interest.

(ii) The adult voluntarily quit in anticipation of discharge or without *good cause*.

(c) For military transition:

(A) When a *caretaker* who is a discharged U.S. military member returns from active duty in a military war zone, the copay is waived for up to six months starting the month after the military member returns home.

(B) The copay waiver ends at the end of the six month period if the *caretaker* becomes employed. The copay waiver ends before the end of the six month period if the *caretaker* returns to active duty.

(d) Under this section child care may be used for work, work search, education hours, military transition activities, or other activities to maintain a part-time or full-time slot at a child care facility.

(e) If the *caretaker* stops participating in the Occupational Training and Child Care program:

(A) The *caretaker*'s copay is waived for up to three months while the *caretaker* is in the process of reengaging into the program.

(B) The waiver ends when the *caretaker* reengages into the Occupational Training and Child Care program.

(C) If the *caretaker* does not reengage within three months, the ERDC certification ends at the end of the three months if the *caretaker* does not reengage in the Occupational Training and Child Care program.

(7) In the ERDC program the cost of dependent child care may be paid for by the Department (is covered) at the beginning of the certification period or may continue to be paid for by the Department (is covered) with no change to the authorized childcare hours if the *caretaker* is on medical leave during the certification period. Medical leave includes a

caretaker on leave due to their own condition or to care for a child in the filing group (see OAR 461-110-0350).

(a) When a *caretaker* is on medical leave the reason for the leave must be verified including diagnosis and prognosis under OAR 461-125-0830, except that parental leave may be authorized for up to three calendar months without medical documentation.

(b) When a *caretaker* is on medical leave during the certification period and meets subsection (a) of this section, the copay is waived starting the month after medical leave begins. The copay waiver -

(A) May not go beyond the last day of the certification period, subject to OAR 461-170-0150.

(B) Ends at the end of the medical leave period, unless the *caretaker* is still on medical leave or requires extended parental leave and new verification is received prior to the end of the month noted on the original documentation, or for parental leave without medical documentation, prior to the end of third calendar month.

(c) When a *caretaker* is on medical leave at the time of initial application or certification, and meets subsection (a) of this section, the copay may be waived. The copay waiver -

(A) May not go beyond the last day of the certification period, subject to OAR 461-170-0150.

(B) Ends at the end of the medical leave period, unless the *caretaker* is still on medical leave or requires extended parental leave and new verification is received prior to the end of the month noted on the original documentation, or for parental leave without medical documentation, prior to the end of the third calendar month.

(8) In the JOBS program, the cost of child care may be covered while the care is necessary to enable the *caretaker* to participate in a *case plan* (see OAR 461-190-0211).

(9) In the ERDC, JOBS, JOBS Plus, and TANF programs, the cost of dependent child care may be paid for (is covered) by the Department, only if all the following are true:

(a) The *child* (see OAR 461-001-0000):

(A) In the ERDC program, is a member of the *benefit group* (see OAR 461-110-0750) and is in the care, control, and custody of an individual in the group.

(B) In the JOBS, JOBS Plus, and TANF programs, lives with the filing group (OAR 461-110-0330).

~~(b) The provider of child care is not in the filing group (OAR 461-110-0310).~~

~~(c) The provider of child care is not the *parent* of a *child* in the filing group (OAR 461-110-0310).~~

~~(10) Coverage of the cost of dependent care is subject to the requirements in OAR chapter 461, including OAR 461-120-0510(3), 461-135-0400, 461-155-0150, 461-160-0193, 461-165-0180, and 461-190-0211.~~

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.700, 411.816, 412.049
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.700, 411.816, 412.049, HB 3073 Oregon 2021 Regular Sess.

461-160-0060 Eff. ~~9-1-16~~07/01/23

Use of Rounding in Calculating Benefit Amount

(1) In the REF and TANF programs, a benefit amount not a whole number of dollars is rounded down to the next lower whole dollar.

~~(2) In the ERDC program, total countable income is rounded down to the next lower whole dollar. The benefit figures are not rounded.~~

(2~~3~~) In the GA, OSIP, OSIPM, and QMB programs, rounding is not used.

(3~~4~~) In the SNAP program:

(a) Except as provided in subsection (b) of this section, when income and deductions are calculated, a figure ending with less than 50 cents is rounded to the next lower dollar and a figure ending with 50 cents or more is rounded to the next higher dollar.

(b) After multiplying the adjusted income by 30 percent, any amount from 1 to 99 cents is rounded up to the next higher dollar.

Statutory/Other Authority~~. Auth.~~: ORS 411.060, 411.404, 411.816, 412.014, 412.049
Statutes/Other~~s.~~ Implemented: 411.060, 411.404, 411.816, 412.014, 412.049

461-165-0030 Eff. ~~1-1-18~~07/01/23
Concurrent and Duplicate Program Benefits

(1) Except as noted in this rule, an individual may not receive benefits from the Department of the same type (that is, cash, medical, or SNAP benefits) for the same period as a member of two or more different benefit groups (see OAR 461-110-0750) or from two or more separate programs. Except as allowed in subsection (c~~g~~) of this section, this provision includes a prohibition against an individual receiving TANF concurrently with another cash assistance program funded under Title IV-E of the Social Security Act.

(a) An individual may receive EA, HSP, and TA-DVS benefits and cash payments from other programs for the same time period.

(b) If a GA recipient becomes eligible for the TANF program, the GA recipient may not receive a TANF cash payment for themselves in the month a GA cash payment was received.

~~(c) A TANF recipient may receive ERDC for a *child* (see OAR 461-001-0000) in the *household group* (see OAR 461-110-0210), but who may not be included in the TANF filing group (see OAR 461-110-0310 and 461-110-0330).~~

~~(d) A *child* who is a member of an ERDC *benefit group* may also be a member of one of the following benefit groups:~~

~~(A) An OSIP-AB *benefit group*.~~

~~(B) A TANF *benefit group* when living with a nonneedy *caretaker relative* (see OAR 461-001-0000), if the *caretaker relative* is not the *parent* (see OAR 461-001-0000) of the *child*.~~

~~(C) A TANF *benefit group* when living with a needy *caretaker relative* receiving SSI.~~

(c~~e~~) An individual in the SNAP program who leaves a filing group (see OAR 461-110-0310 and 461-110-0370) that includes an individual who abused them and enters a *domestic violence shelter* (see OAR 461-001-0000) or *safe home* (see OAR 461-001-0000) for survivors~~victims~~ of *domestic violence* (see OAR 461-001-0000) may receive SNAP benefits twice during the month the individual enters the *domestic violence shelter* or *safe home*.

(d~~f~~) Except in the QMB-DW and QMB-SMF programs, a QMB recipient may also receive medical benefits from OSIPM, REFM, MAGI Child, MAGI Parent or Other Caretaker Relative, or MAGI Pregnant Woman. QMB-DW and QMB-SMF recipients may not receive any other medical assistance program offered under the state plan (see OAR 461-135-0730).

(eg) An individual may receive Chafee (see OAR 413-030-0400 to 413-030-0455) and TANF benefits during the same time period. As of January 1, 2013, receipt of both Chafee and TANF benefits will not result in an overpayment.

(fh) An individual receiving *Employment Payments* (see OAR 461-001-0025 and 461-135-1270) who becomes eligible for TANF in the same month may receive both benefits in the same month.

(gi) An individual receiving JPI (see OAR 461-135-1260) who becomes eligible for Pre-TANF or TANF in the same month may receive both benefits in the same month.

~~(j) An individual may start TANF benefits in the same and final month that ERDC benefits are being received.~~

(2) An individual may not receive benefits of the same type (that is, cash, medical, or SNAP benefits) for the same period from both Oregon and another state or tribal food distribution program, except as follows:

(a) Medical benefits may be authorized for an eligible individual if the individual's provider refuses to submit a bill to the Medicaid agency of another state and the individual would not otherwise receive medical care.

(b) Cash benefits may be authorized for an individual in the Pre-TANF program if benefits from another state will end by the last day of the month in which the individual applied for TANF.

(3) In the SNAP program, each individual who has been included as a member of the filing group in Oregon or another state is subject to all of the restrictions in section (2) of this rule.

(4) An REF or TANF filing group may not receive REF or TANF benefits during the same month that an individual in that group was enrolled in or received assistance from the Office of Refugee Resettlement Matching Grant Program.

Statutory/Other Authority~~. Auth.~~: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 412.124, 413.085, 414.025, 414.685, 414.826, 414.839
Statutes/Other~~s.~~ Implemented: ORS 329A.500, 409.050, 411.060, 411.070, 411.117, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 412.124, 413.085, 414.025, 414.685, 414.826, 414.839

461-165-0120 Eff. ~~1-1-18~~7/01/23
Benefits for an ~~Client~~ Individual in an Acute Care Hospital

(1) In the REF, REFM, and TANF programs, regular monthly benefits continue when an ~~client~~ individual enters an acute care hospital. The monthly benefits remain unchanged until the ~~client~~ individual returns home or enters some other living arrangement. An authorized representative designated by the ~~client~~ individual or ~~the branch may be used if necessary~~as otherwise allowed under OAR 461-115-0090 may be used if necessary.

~~(2) In the ERDC program, regular monthly benefits continue if a client will be in the acute care hospital for less than 30 days. If the client will be in the acute care hospital for 30 days or more or until death, the client's needs are determined as if the client were in a nursing facility.~~

(3) In the GA, OSIP, OSIPM, and QMB programs, an individual may receive benefits in an acute care hospital as long as they meet program eligibility requirements.

(4) In the SNAP program, regular monthly benefits continue if the ~~client~~ individual will be in ~~his or her~~their own home 50 percent of the time or more. If the ~~client~~ individual will be in an ~~institution~~ acute care hospital for more than 50 percent of a calendar month, the ~~client~~ individual is not eligible for SNAP benefits.

Statutory/Other Authority~~. Auth.~~: ORS 329A.500, 409.050, 411.060, 411.404, 411.816, 412.049, 413.085, 414.685
Statutes/Other~~s.~~ Implemented: ORS 329A.500, 409.010, 411.060, 411.404, 411.816, 412.049

461-170-0010 Eff. ~~9/27/22~~07/01/23
Reporting Changes - Overview

An individual is required to report a change in circumstances in accordance with the reporting system in which the individual participates, OAR 461-170-0011, and --

(1) For each program in which an individual participates, the Department determines the appropriate reporting system. The Department's reporting systems are Change Reporting System (CRS), Simplified Reporting System (SRS), and Transitional Benefit Alternative (TBA). In addition to any required report form, when an individual is required by this division of rules to report a change in circumstances, the report may be made by telephone, office visit, report form, or other written notice. The report must be made as follows:

(a) An individual using CRS must report a change according to OAR 461-170-0011.

(b) An individual using SRS must report a change according to OAR 461-170-0011 and 461-170-0102. The Periodic Report form is processed according to OAR 461-170-0011 and 461-170-0101 to 461-170-0104.

(c) An individual using TBA is not required to report any change.

(2) A change is considered reported effective the date an individual, authorized representative, or ineligible student reports the information to a *branch office* (see OAR 461-001-0000).

(3) In the ~~ERDC and~~ SNAP program~~s~~, when multiple changes are reported at the same time, they must be acted on at the time of reporting and have the same effective date.

(4) A change reported by an individual, authorized representative, or ineligible student for one program is considered reported for all programs in which that individual participates.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049
Statutes/Other Implemented: ORS 409.010, 411.060, 411.070, 411.081, 411.087, 411.404, 411.816, 412.014, 412.049

461-170-0011 Eff. ~~5/01/22~~07/01/23
Changes That Must Be Reported

(1) A change in employment status is considered to occur as follows:

(a) For a new job, the change occurs the first day of the new job.

(b) For a job separation, the change occurs on the last day of employment.

(2) A change in source of income is considered to occur as follows:

(a) For earned income, the change occurs upon the receipt by the individual of the first paycheck from a new job or the first paycheck reflecting a new rate of pay.

(b) For unearned income, the change occurs the day the individual receives the new or changed payment.

(3) An individual must report, orally or in writing, the following changes:

~~(a) In the ERDC program, an individual must report the following changes within 10 days of occurrence:~~

~~(A) A change in child care provider.~~

~~(B) A change in employment status.~~

~~(C) A change in mailing address or residence.~~

~~(D) A change in membership of the filing group (see OAR 461-110-0350).~~

~~(E) A member of the filing group is discharged from the U.S. military and returning from active duty in a military war zone.~~

~~(F) A change in income above the 250 percent federal poverty level (FPL) or 85 percent state median income (SMI), whichever is higher, as described in OAR 461-155-0180, that is expected to continue.~~

(a~~b~~) In the SNAP program:

(A) An ABAWD residing in one of the SNAP *time limit areas* (see OAR 461-135-0520), who is working, paid or unpaid, and assigned to CRS, SRS, or TBA must report a change in work hours when work hours fall below 20 hours per week. This change must be reported within 10 days of occurrence.

(B) An individual assigned to CRS must report any of the following changes within 10 days of occurrence:

(i) ERetroactively effective October 1, 2021, a change in earned income of more than $125.

(ii) ERetroactively effective October 1, 2021, a change in unearned income of more than $125.

(iii) A change in source of income.

(iv) A change in membership of the filing group (see OAR 461-110-0370) and any resulting change in income.

(v) A change in residence and the shelter costs in the new residence.

(vi) A change in the legal obligation to pay child support.

(vii) When the sum of cash on hand, stocks, bond, and money in a bank or savings institution account reaches or exceeds program resource limits.

(viii) Acquisition or change in ownership of a non-excluded vehicle.

(C) An individual assigned to SRS must report by the tenth day of the month following the month of occurrence when:

(i) The monthly income of the filing group exceeds the SNAP *countable* (see OAR 461-001-0000) income limit.

(ii) A member of the *financial group* (see OAR 461-110-0530) has lottery or gambling winnings equal to or in excess of the amount listed as the resource limit in OAR 461-160-0015(7)(a).

(D) An individual assigned to TBA is not required to report any changes except for the requirement set out in paragraph (3)(b)(A).

(be) For Employment Payments (see OAR 461-135-1270) and JPI (see OAR 461-135-1260), an individual must follow the same reporting requirements as an SNAP client individual assigned to SNAP program CRS, SRS, or TBA reporting systems (see OAR 461-170-0010).

(cd) In the GA, OSIP, OSIPM, and QMB programs, an individual must report all changes that may affect *eligibility* (see OAR 461-001-0000) or benefit level within 10 days of occurrence, including any of the following changes:

(A) A change in employment status.

(B) A change in health care coverage.

(C) A change in membership of the *household group* (see OAR 461-110-0210).

(D) A change in marital status.

(E) A change in residence.

(F) A change in resources.

(G) A change in source or amount of income.

(H) Except for the QMB programs, out-of-pocket medical expenses.

(I) For a *resident of a public institution* (see OAR 461-135-0950) whose medical benefits have been suspended under OAR 461-135-0950, a change in incarceration status.

(dc) In the REF, SFPSS, and TANF programs, an individual assigned to CRS must report any of the following changes within 10 days of occurrence:

(A) Acquisition or change in ownership of a non-excluded vehicle.

(B) A change in earned income more than $100.

(C) Employment separation.

(D) A change in membership of the *household group*.

(E) A change in marital status or other changes in membership of the filing group.

(F) A change in mailing address or residence.

(G) A change in pregnancy status of any member of the filing group.

(H) A change in source of income.

(I) A change in unearned income more than $50.

(J) A change in who pays the shelter costs if the costs will be paid by a non-custodial *parent*.

(K) Sale or receipt of a resource that causes total resources to exceed program resource limits.

(ce) In the REFM program, an individual must report the following changes within 10 days of occurrence:

(A) A change in membership of the *household group*.

(B) A change in residence.

(C) A change in pregnancy status of any member of the filing group.

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 329A.500, 409.010, 409.050, 411.060, 411.070, 411.081, 411.404, 411.704, 411.706, 411.816, 411.825, 411.837, 412.014, 412.049, 413.085, 414.685, 414.826

461-170-0200 Eff. ~~1-1-14~~07/01/23

State and Federal Government-Initiated Changes

An ~~client~~ individual is not required to report any of the following changes:

(1) Periodic cost-of-living adjustments to the federal Black Lung Program, SSB (Social Security Benefits), SSDI, SSI, and veterans assistance under Title 38 of the United States Code.

(2) Periodic cost-of-living adjustments to ~~ERDC,~~ GA, OSIP, REF, SFPSS, and TANF standards.

(3) Other changes in eligibility criteria based on legislative or regulatory actions.

Statutory/Other Authority~~. Auth.~~: ORS 411.060, 411.404, 411.816, 412.009, 412.014, 412.049
Statutes/Other~~s.~~ Implemented: ORS 411.060, 411.404, 411.816, 412.009, 412.014, 412.049, 412.089

461-175-0210 Eff. ~~10/01/22~~07/01/23
Notice Situation; Individual Moved or Whereabouts Unknown

(1) In all programs except the SNAP program, to end benefits for an individual who has moved out of Oregon and no longer meets residency requirements under OAR 461-120-0010, the Department sends the following *decision notice* (see OAR 461-001-0000):

(a) In the ~~ERDC,~~ OSIP, OSIPM, QMB, REF, REFM, and TANF programs:

(A) The Department sends a *timely continuing benefit decision notice* (see OAR 461-001-0000) to the individual who has moved out of Oregon.

(B) The Department sends a *basic decision notice* (see OAR 461-001-0000) if the individual becomes eligible for benefits in another state.

(b) In the GA program:

(A) No *decision notice* is required to end housing assistance payments.

(B) The Department sends a *timely continuing benefit decision notice* to end Personal Incidental Fund and utility assistance payments.

(c) For *Employment Payments* (see OAR 461-001-0025 and 461-135-1270) and JPI (see OAR 461-135-1260), no *decision notice* is required if the Department determines that the *benefit group* (see OAR 461-110-0750) has moved out of Oregon.

(2) In the GA, OSIP, OSIPM, and QMB programs,

(a) If Department mail or benefits have been returned with no forwarding address, the Department gives the individual the benefits if the individual's whereabouts become known during the period covered by the returned benefits.

(b) If Department mail or benefits have been returned with no forwarding address and the individual's whereabouts remain unknown, the Department ends benefits by sending a *basic decision notice.*

(3) In the SNAP program and for JPI --

(a) When the *filing group* is participating in the Change Report System (CRS) and:

(A) Department mail or benefits have been returned with no forwarding address, or with an Oregon address not yet reported to ODHS, the Department shall allow the filing group 10 days to meet residence and shelter cost reporting requirements under OAR 461-170-0011. If the

information is not provided, the Department sends a *timely continuing benefit decision notice*.

(B) Department mail or benefits have been returned with an address outside of Oregon, no *decision notice* is required to end benefits.

(b) When the *filing group* is participating in the Simplified Reporting System (SRS) or Transitional Benefit Alternative (TBA),

(A) The Department shall not end SNAP program benefits when Department mail or benefits have been returned.

(B) The Department shall end benefits when the *head of household* (see OAR 461-001-0015) reports they moved out of Oregon and no longer meet residency requirements under OAR 461-120-0010, or when they are applying for benefits in another state. No *decision notice* is required.

(c) For JPI, notwithstanding any provision in this section and regardless of reporting system, no *decision notice* is required.

(4) Effective June 15, 2022, in the ~~ERDC,~~ REF, TA-DVS, and TANF programs –

(a) The Department shall not end program benefits due to return of Department mail or benefits. This includes when there is no forwarding address and the individual's whereabouts remain unknown.

(b) In the REF and TANF Programs,

(A) When an individual's whereabouts become unknown based on information other then return mail and the source of the information is another governmental agency; a private, non-profit agency; or first-hand knowledge of an ODHS staff member learned from the course of business, the Department shall allow the filing group 10 days to make their whereabouts known. If the information is not provided, the Department shall end benefits by sending the following *decision notice* to their last known address:

(i) Except for Employment Payments, a *timely continuing benefit decision notice*.

(ii) For Employment Payments, no *decision notice* is required.

(B) The Department shall give an individual the benefits that were returned if their whereabouts become known within 12 calendar months after issuance.

(5) See OAR 461-165-0130 for when benefits may be sent out of Oregon.

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.095, 411.404, 411.816, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.095, 411.404, 411.816, 412.049

461-175-0222 Eff. ~~1-1-16~~07/01/23
Notice Situations - Expiration of Certification Period; ~~ERDC,~~ SNAP, TANF

In the ~~ERDC,~~ SNAP~~,~~ and TANF programs:

(1) ~~Except in the ERDC program, t~~The Department must provide a household certified for one month or certified in the second month of a two-month *certification period* (see OAR 461-001-0000) a notice of expiration at the time of certification.

~~(2) In the ERDC program, each household must receive a notice of expiration prior to the last month of the *certification period*.~~

~~(3) In the ERDC program, the notice of expiration must contain:~~

~~(a) The date the *certification period* expires.~~

~~(b) A statement that to receive benefits, the client must reapply and be found eligible for a new benefit amount.~~

~~(c) The household's right to request a contested case hearing if the reapplication is denied or if the household objects to the benefit amount.~~

(2~~4~~) In the SNAP program, each household other than those covered under section (1) of this rule must receive a notice of expiration before the first day of the last month of the *certification period* (established per OAR 461-115-0450), but not before the first day of the next-to-the-last month.

(3~~5~~) In the SNAP program, notice of expiration under this rule is provided to the filing group (see OAR 461-110-0310 and 461-110-0370) and must contain all of the following:

(a) The date the *certification period* expires.

(b) The date by which a household must submit an application for recertification to receive uninterrupted benefits.

(c) The consequences of failure to apply for recertification in a timely manner.

(d) The right to receive an application form upon request and to have it accepted as long as it contains a signature and a legible name and address.

(e) Information on alternative submission methods available to households that are not able to come into the certification office or do not have an authorized representative and how to exercise these options.

(f) The address of the office where the application must be filed.

(g) The household's right to request a contested case hearing if the recertification is denied or if the household objects to the benefit amount.

(h) A statement that any household consisting only of Supplemental Security Income (SSI) applicants or recipients is entitled to apply for SNAP program benefits recertification at an office of the Social Security Administration.

(i) A statement that failure to attend an interview may result in delay or denial of benefits.

(j) A statement that the household is responsible for rescheduling a missed interview and for providing required verification information.

(k) A statement that there is ~~client has~~ no right~~s~~ to continuation of benefits after the SNAP program *certification period* expires; and that to receive benefits, the ~~client~~ individual must reapply and be found eligible for a new benefit amount after the end of the *certification period*, including an ~~client~~ individual who is receiving continuation of benefits when ~~his or her~~their SNAP program *certification period* ends.

(~~4~~6) In the TANF program, each household other than those covered under section (1) of this rule must be sent --

(a) Before the first day of the last month of the *certification period* (see OAR 461-001-0000 and 461-115-0430), but not before the first day of the next-to-the-last month, a recertification packet that contains application forms, deadlines, and information about the consequences of not reapplying on time; and

(b) A *basic decision notice* (see OAR 461-001-0000) about the expiration of the *certification period* (see OAR 461-001-0000 and 461-115-0430).

Statutory/Other Authority~~. Auth.~~: ORS 409.050, 411.060, 411.070, 411.816, 412.049
Statutes/Other~~s.~~ Implemented: ORS 409.010, 411.060, 411.070, 411.816, 412.049

461-175-0270 Eff.
~~9/27/22~~07/01/23
Notice Situation; SRS or TBA

(1) When the Department takes action on information reported on the Periodic Report form, the Department sends a *continuing benefit decision notice* (see OAR 461-001-0000) for individuals in the ~~ERDC,~~ OSIP, OSIPM, QMB, REF, REFM, SNAP, and TANF programs. The notice includes the amount of income used to determine the benefits or ineligibility.

(2) For all changes not reported on the Periodic Report form, which result in a closure or reduction in benefits, the Department sends a *timely continuing benefit decision notice*.

(3) When the Department changes the reporting system from one reporting system to another reporting system, the Department provides a *continuing benefit decision notice* if the change occurs at a time other than at the start of a *certification period* (see OAR 461-001-0000).

Statutory/Other Authority: ORS 411.060, 411.070, 411.095, 411.111, 411.404, 411.816, 412.049
Statutes/Other Implemented: ORS 411.060, 411.070, 411.095, 411.111, 411.404, 411.816, 412.049

461-175-0280 Eff. ~~9/27/22~~07/01/23

Notice Situation; Failure to Submit Periodic Report ~~for SRS or ERDC Reapplication~~; SNAP

~~(1) In the ERDC program, the Department sends a *continuing benefit decision notice* (see OAR 461-001-0000) to close benefits when the *benefit group* (see OAR 461-110-0750) fails to return the reapplication form. The case is closed on the last day of the last month of the *certification period* (see OAR 461-001-0000).~~

~~(2)~~ In the SNAP program~~,~~:

(1~~a~~) The Department sends a *continuing benefit decision notice* when a *benefit group* in Simplified Reporting System (SRS) fails to return a *complete* (see OAR 461-170-0101) Periodic Report form by the due date. The notice informs the *benefit group* that:

(a~~A~~) The Periodic Report form was not received by the due date.

(b~~B~~) The *benefit group* has until the end of the *continued due month* (see OAR 461-170-0101) to provide the Periodic Report form to receive non-prorated benefits for the *reinstate month* (see OAR 461-170-0101).

(c~~C~~) If the Periodic Report form is not received by the Department by the last day of the *continued due month*, SNAP program benefits will be closed effective the last day of the *continued due month*.

(2~~b~~) The Department sends a *continuing benefit decision notice* (see OAR 461-001-0000) to close benefits when the benefit group fails to return a *complete* Periodic Report form by the due date. The SNAP program benefits will be closed effective the last day of the *continued due month*.

(3~~c~~) The Department allows a *reinstate month* during which a *benefit group* may submit a *complete* Periodic Report form and have the SNAP *certification period* reinstated. A *complete* Periodic Report form received after the last day of the *reinstate month* shall not reinstate SNAP benefits.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.095, 411.816
Statutes/Other Implemented: ORS 409.010, 409.050, 409.610, 411.060, 411.070, 411.087, 411.095, 411.816, 411.825, 411.837

(1) Except as provided in section (5) of this rule, when benefits in any Department program except a medical program and the SNAP program will end or be reduced after a specific period of time, the Department may issue a *decision notice* (see OAR 461-001-0000) informing the *benefit group* (see OAR 461-110-0750) of the date benefits will end or be reduced, and no further *decision notice* is required.

(2) Except as provided in section (5) of this rule, in any Department program except a medical program and the SNAP program, if the *benefit group* was informed in writing when the benefits began that the *benefit group* would receive benefits only for a specific period of time a *basic decision notice* (see OAR 461-001-0000) may be used to--

(a) Deny an application to start or continue benefits after the completion of a *certification period* (see OAR 461-001-0000) or to approve benefits at a level lower than the prior *certification period*.

(b) Indicate that benefits have been ended or reduced when no timely application is submitted.

(3) A *basic decision notice* is used when a special need allowance granted for a specific period of time is removed at the end of the specified period and the *benefit group* was informed of this in writing when the allowance began. A *timely continuing benefit decision notice* (see OAR 461-001-0000) is required if stopping the special need allowance results in benefit closure.

(4) In the JOBS Plus program, a *basic decision notice* is used if--

(a) An employer submits a wage reimbursement billing and the Department calculates a supplement (see OAR 461-190-0416 about supplements);

(b) The *benefit group* received a *timely continuing benefit decision notice* that the method of payment would be changed from cash to employer-paid wages; and

(c) The notice specified the period of time that benefits would be diverted.

(5) No additional *decision notice* is required when:

(a) Notwithstanding OAR 461-115-0010(6), when a *benefit group* submits an application for a program from which they currently are receiving benefits.

(b) In the OSIPM program:

(A) An individual's patient liability under OAR 461-160-0610 or *participant fee* (see OAR 461-001-0035) returns to the previous amount after the Department sent the individual a *basic decision notice* for a decrease in the patient liability or *participant fee* due to a one-time allowable deduction and

that notice also specified when the deduction no longer would apply causing the patient liability or *participant fee* to return to the previous amount; or

(B) An individual's benefits are being closed or reduced and the Department sent the individual a *basic decision notice* of eligibility and a simultaneous *continuing benefit decision notice* (see OAR 461-001-0000) because the individual's circumstances changed between the date of the individual's application and the date of the Department's eligibility decision and the change caused the individual's benefits to be reduced or closed.

~~(c) In the ERDC program when a filing group (see OAR 461-110-0310 and 461-110-0350) is receiving *priority processing* (see OAR 461-170-0150(2)) but does not return postponed verification to the Department by the last day of the month in which the application period ends (see OAR 461-115-0190).~~

(cd) A *decision notice* that included the eligibility begin and end dates for the three consecutive months of *Employment Payments* (see OAR 461-001-0025 and 461-135-1270) was given and the three-month eligibility period ends.

(de) A *decision notice* that informed the JPI *benefit group* in writing, when their benefits began, that they would receive JPI (see OAR 461-135-1260) benefits only for a specific period of time.

~~(f) A *decision notice* that included the eligibility begin and end dates was given for the reduced ERDC copay described in OAR 461-155-0150(13) and the three-month eligibility period ends.~~

(eg) A *decision notice* that included the eligibility begin and end dates was given for TA-DVS program benefits and the 90-day eligibility period ends.

(6) In the SNAP program:

(a) A *basic decision notice* is used to close benefits if the *benefit group* was informed in writing, when their benefits began, that they would receive benefits only for a specific period of time.

(b) No *decision notice* is required if the individual is provided a *decision notice* at the time of application or redetermination that –

(A) The allotment of the *benefit group* would vary from month to month and listed the anticipated changes;

(B) In the case the individual applied at the same time for both cash assistance and SNAP benefits, the SNAP benefits would be reduced or closed upon approval of the cash assistance; or

(C) In the case of a *benefit group* receiving benefits under expedited services with postponed verification:

(i) The expedited services benefits would close if the Department did not receive the postponed verification within the timeframe established under OAR 461-115-0690.

(ii) The expedited services benefits may be adjusted beyond the timeframe established under OAR 461-115-0690 based on the verified information provided to the Department without further notice.

Statutory/Other Authority: ORS 183.417, 411.060, 411.070, 411.117, 411.404, 411.706, 411.816, 412.006, 412.014, 412.049
Statutes/Other Implemented: ORS 183.417, 411.060, 411.070, 411.117, 411.404, 411.706, 411.816, 412.006, 412.014, 412.049

461-175-0305 Eff. ~~9/27/22~~07/01/23

Notice Situation; Removing an Individual from a Benefit Group~~;~~ ~~(~~REF, REFM, SNAP, TANF~~)~~ ~~or Need Group (ERDC)~~

(1) To remove an individual from a *benefit group* (see OAR 461-110-0750), the following notices are used:

(a) A *continuing benefit decision notice* (see OAR 461-001-0000) is used when the removal is based on information reported on the Periodic Report form.

(b) A *timely continuing benefit decision notice* (see OAR 461-001-0000) is used when the removal is not based on the Periodic Report form.

~~(2) In the ERDC program, the Department sends a *timely continuing benefit decision notice* to remove an individual from the *need group* (see OAR 461-110-0630).~~

(~~2~~3) In the TANF program, if a *child* (see OAR 461-001-0000) is removed from the *benefit group* as a result of a court order or a voluntary placement in foster care by the child's *caretaker relative* (see OAR 461-001-0000), a *basic decision notice* (see OAR 461-001-0000) is used.

Statutory/Other Authority: ORS 411.060, 411.095, 411.404, 411.816, 412.049
Statutes/Other Implemented: ORS 411.060, 411.095, 411.404, 411.816, 412.049

461-180-0010 Eff. ~~10-1-17~~07/01/23
Effective Dates; Adding a New Person to an Open Case

(1) In the following programs, the effective date for adding an individual (other than an assumed eligible newborn) to the *benefit group* (see OAR 461-110-0750) is one of the following:

(a) In the OSIPM program, the date benefits are requested for the individual establishes a *date of request* (see OAR 461-115-0030) for the individual. The effective date for the individual is determined in accordance with OAR 461-180-0090.

(b) In the REFM program, it is whichever occurs first:

(A) The date the individual requests benefits, if the individual was eligible as of that date.

(B) The date all eligibility requirements are met.

(c) In the SNAP program:

(A) If adding the individual increases benefits, it is the first of the month after the filing group (see OAR 461-110-0310 and 461-110-0370) reports the person has joined the *household group* (see OAR 461-110-0210). If verification is requested, the effective date for the change is:

(i) The first of the month following the date the change was reported if verification is received by the Department no later than the due date for the verification.

(ii) The first of the month following the date the verification is received by the Department if received after the verification due date.

(B) If adding the individual reduces benefits, it is the first of the month following the month in which the notice period ends (see OAR 461-175-0050).

(d) In the GA, OSIP, REF, SFPSS, and TANF programs, it is the date on which all eligibility requirements are met and verified. If benefits have been issued for the month and adding the new person would reduce benefits, the person is added the first of the month following the month in which the notice period ends (see OAR 461-175-0050).

(e) In the QMB-BAS and QMB-DW programs, it is the first of the month after the new individual has been determined to meet all QMB eligibility criteria and the Department receives the required verification.

(f) In the QMB-SMB program, it is the first of the month in which the new individual has been determined to meet all QMB-SMB eligibility criteria and the Department receives the required verification.

~~(g) In the SFPSS, TA-DVS, and TANF programs, for adding a *child* (see OAR 461-001-0000) to be covered by a provider-direct child care payment, it is the first of the month in which the *child* is added to the *benefit group*.~~

(2) In the following programs, the effective date for adding an assumed eligible newborn to the *benefit group* is one of the following:

(a) In the OSIPM and REFM programs, it is the date of birth if all the following paragraphs are true. If any of the following paragraphs is not true, the newborn is added to the *benefit group* in accordance with section (1) of this rule.

(A) A request for benefits is made within one year of the birth. For purposes of this paragraph, a telephone call from the attending physician, another licensed practitioner, a hospital, or the family is considered a request for benefits.

(B) The newborn has continuously lived with the ~~mother~~ individual who gave birth to the newborn since the date of birth.

(C) The ~~mother~~ individual who gave birth to the newborn was receiving OSIPM on the date of birth, even if ~~she~~ they are~~is~~ not currently eligible for benefits.

(b) In the SFPSS and TANF programs, it is:

(A) The date of birth, if all eligibility requirements are met and verified within 30 days after the birth; or

(B) The date all eligibility factors are met and verified, if the verification is completed more than 30 days after the date of birth.

~~(3) In the ERDC program, the effective date for adding an individual to the *need group* (see OAR 461-110-0630) or *benefit group* is as follows:~~

~~(a) If adding the individual to the *need group* will decrease the copay, the effective date is the first of the month after the client reports the person has joined the household.~~

~~(b) If adding the individual to the *need group* increases the copay--for instance, because the individual receives income--the effective date is the first of the month following the end of the decision notice period (see OAR 461-175-0050).~~

~~(c) The effective date for adding a *child* to the *benefit group* - that is, covering the cost of the child's care - is the earliest of the following:~~

~~(A) For newborns, the date of birth, if all eligibility requirements are met and verified within 45 days after the birth.~~

~~(B) For all other children, the first of the month in which the change is reported, if all eligibility requirements are met and verified within 45 days.~~

~~(C) For newborns and other children, if eligibility cannot be verified within 45 days, the effective date is the first of the month in which all eligibility factors are met and verified.~~

Statutory/Other Authority~~. Auth.~~: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685
Statutes/Other~~s.~~ Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049

461-180-0020 ~~TECH~~ Eff. ~~12/14/21~~07/01/23
Effective Dates; Changes in Income or Income Deductions That Cause Increases

~~For all programs in Chapter 461, except the ERDC program, t~~This rule is used to determine the effective date when a change in income or income deductions causes an increase in benefits. The effective date is one of the following:

(1) In the GA, REF, SFPSS, and TANF programs, the effective date for an anticipated change reported before the payment month is the first of the payment month in which it will occur. If the change is not reported until the month it occurs or later, the effective date is the first of the month following the month in which the change was reported.

(2) In the SNAP program:

(a) The effective date when verification is not requested is the first of the month following the date the change was reported.

(b) The effective date if verification is requested is:

(A) The first of the month following the date the change was reported if verification is received no later than the due date for the verification.

(B) The first of the month following the date the verification is received by the Department, if received after the verification due date.

(3) In the OSIPM and QMB programs, the effective date for increases resulting from reported changes is determined as follows:

(a) If, based on the reported change, the individual is determined eligible for a new program with a higher benefit level, the effective date for the new program is determined in accordance with OAR 461-180-0090.

(b) For changes in income or increased deductions due to changes to an individual's marital status or number of eligible dependents that reduce patient liability under OAR 461-160-0610 or the OSIPM-EPD *participant fee* (see OAR 461-001-0035), the effective date is the first of the month in which the change is reported or discovered.

(c) For medical costs allowed in accordance with OAR 461-160-0030 that reduce the patient liability or *participant fee*:

(A) One-time and ongoing costs that have already been paid when the change is reported are allowed in the month they are reported.

(B) For one-time and ongoing costs that have been incurred but not paid, the change is effective the month the individual reports they paid the cost or began making payments.

(d) When the decrease in patient liability is caused by a higher maintenance standard due to a change in service setting, the effective date is the date the individual moves into the new service setting.

(e) When a decrease in patient liability is caused by a change in income and a change in service setting that occurs in the same month, the effective date is the day the individual moves into the new service setting.

(f) When the decrease in *participant fee* is caused by a higher maintenance standard due to a change in service setting or a combination of a higher maintenance standard and another change that is reported or discovered in the same month, the effective date is the first of the month the individual moves into the new service setting.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 409.010, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049

461-180-0050 Eff. ~~1~~07/01/23
Effective Dates; Suspending or Closing Benefits and JOBS and REP Support Service Payments

(1) This rule explains the effective date for closing or suspending benefits for the entire *benefit group* (see OAR 461-110-0750) and the effective date for ending JOBS and REP support service payments.

(2) In all programs ~~except the ERDC program~~, when the only individual in a *benefit group* dies, the effective date of the closure is:

(a) In the REF, SNAP, and TANF programs, the last day of the month in which the death occurred.

(b) In all other programs, the date of the death.

(3) For all closures and suspensions not covered by section (2) of this rule, the effective date is determined as follows:

(a) When prospective eligibility is used, the effective date for closing or suspending benefits is the last day of the month in which the notice period ends.

(b) For a pregnant individual receiving benefits of the OSIPM program, the effective date for closing benefits is no earlier than the last day of the calendar month in which the 60th day after the last day of pregnancy falls, except at the individual's request.

(c) For an individual who is receiving medical assistance and becomes incarcerated with an expected stay of a year or less, the effective date for suspending medical benefits is the effective date on the *decision notice* (see OAR 461-001-0000).

(d) The effective date for ending support service payments authorized under OAR 461-190-0211 is the earlier of the following:

(A) The date the related JOBS or REP activity is scheduled to end.

(B) The date the individual no longer meets the requirements of OAR 461-190-0211.

(e) In the OSIP, OSIPM, and QMB programs, notwithstanding any other provision in Chapter 461, benefits can be closed retroactively under any of the conditions listed below:

(A) The individual has moved out of state, requested closure of benefits prior to the move, but the Department failed to take the action. The effective date is the end of the month prior to the month in which the individual established residency in the new state.

(B) In the QMB programs, the individual became disenrolled from Medicare. The effective date is the end of the month prior to the month the individual was disenrolled.

(C) The effective date of a retroactive closure described in paragraph (A) above cannot be before the end of the month in which medical claims were incurred and paid.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.006, 412.009, 412.014, 412.049
Statutes/Other Implemented: ORS 409.010, 411.060, 411.070, 411.404, 411.706, 411.816, 412.006, 412.009, 412.014, 412.049

461-180-0070 Eff. ~~4/01/21~~07/01/23
Effective Dates; Initial Month Benefits

(1) In the EA program, the effective date for opening the case is the day benefits are issued to the *benefit group* (see OAR 461-110-0750). For a *benefit group* whose only eligible child is an unborn, the effective date cannot be earlier than the first day of the calendar month preceding the month in which the due date falls.

~~(2) In the ERDC program, the effective date for starting benefits is one of the following:~~

~~(a) The first day of the month in which the request for benefits is made if –~~

~~(A) All *eligibility* (see OAR 461-001-0000) requirements are met in that month; and~~

~~(B) Verification is provided within the application processing timeframes.~~

~~(b) If all *eligibility* requirements are not met in the month of request, the effective date is the first day of the month in which they are met, if verification is provided within the application processing timeframes.~~

~~(c) For a *benefit group* that received TANF program benefits within the 30 days before applying for ERDC program benefits, the effective date is the first of the month following closure of their TANF program benefits.~~

(2~~3~~) In the GA program, the effective date for the *initial month* (see OAR 461-001-0000) of benefits is --

(a) For individuals who filed an application for SSI benefits prior to applying for GA benefits, the date the individual completes the GA application process and meets all *eligibility* requirements under OAR 461-135-0700.

(b) For individuals who did not file an application for SSI benefits prior to applying for GA benefits, the first of the month following the date the individual completes the GA application process and meets all *eligibility* requirements under OAR 461-135-0700.

(3~~4~~) In the OSIP program, the effective date for the *initial month* of benefits is whichever of the following occurs first:

(a) The date an individual requests benefits, if the individual was eligible as of that date.

(b) The date all *eligibility* requirements are met.

(45) In the REF program, when a *filing group* (see OAR 461-110-0430) makes an initial application, the effective date for starting benefits is:

(a) If all *eligibility* requirements, including an interview, are completed by the 30th day from the *filing date* (see OAR 461-115-0040), the effective date for starting benefits is the *filing date*.

(b) If all *eligibility* requirements are not met by the 30th day from the *filing date*, a new *filing date* must be established.

(56) In the TANF program, when a *filing group* (see OAR 461-110-0330) makes an initial application or applies after the end of the *certification period* (see OAR 461-001-0000), the effective date for starting TANF benefits is one of the following:

(a) Except as provided in subsections (b) to (d) of this section, if all *eligibility* requirements, including a TANF interview, are completed by the 30th day from the *filing date*, the effective date for starting benefits is the *filing date*. If all *eligibility* requirements are not met by the 30th day from the *filing date*, a new *filing date* must be established.

(b) If the only eligible child is an unborn, the effective date may not be earlier than the first day of the calendar month prior to the month in which the due date falls.

(c) For an individual in the Pre-TANF program, the effective date for the *initial month* of benefits is the date the Pre-TANF program ends as provided in OAR 461-135-0475.

(d) For a JOBS support service payment, the effective date is the date the individual meets all *eligibility* requirements in OAR 461-190-0211.

(67) In the SFPSS program, when moving a TANF program recipient to SFPSS, the effective date for the *initial month* of SFPSS program benefits is:

(a) Except as provided in subsection (b) of this section, the first of the month following the day all *eligibility* requirements are met and verified.

(b) If the day all *eligibility* requirements are met and verified falls after the "compute deadline," the *initial month* of SFPSS program benefits will be the first of the month following the month after "compute deadline." For purposes of this rule, "compute deadline" means the Department computer system monthly deadline after which changes will not take effect until the month following the first of the next month.

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.706, 411.878, 412.006, 412.014, 412.049, 413.085, 414.685

Statutes/Other Implemented: ORS 329A.500, 409.010, 409.050, 411.060, 411.070, 411.081, 411.087, 411.404, 411.706, 411.878, 412.006, 412.014, 412.049, 412.064, 413.085, 414.685

461-180-0100 Eff. ~~7-1-18~~07/01/23
Effective Dates; Eligibility Following Closure

The new effective date of eligibility following closure of benefits or following the end of a certification period is determined as follows:

(1) In the SNAP program, see OAR 461-115-0450.

~~(2) In the ERDC program, eligibility starts the first day of the month of the date of request.~~

(2~~3~~) In the REF and TANF programs:

(a) Eligibility starts on the date provided by OAR 461-180-0070 for REF and TANF unless the ~~client~~ applicant meets the requirements of subsection (b) of this section.

(b) Eligibility starts the first day of the month following closure if:

(A) The ~~client~~ applicant contacts the Department during the month of closure; and

(B) Submits to the Department a complete application not later than the end of the month following closure.

(3~~4~~) In all programs other than the ~~ERDC,~~ REF, SNAP, and TANF programs:

(a) If the ~~client~~ individual completes the application process within the applicable time period described in chapter 461 of the Oregon Administrative Rules, eligibility starts on the first day of the month following closure if the filing group meets all eligibility requirements on that date and if --

(A) The filing group established a *date of request* (*see* OAR 461-115-0030) prior to closure; or

(B) The Department initiated a redetermination of eligibility prior to closure.

(b) If the ~~client~~ individual does not complete the application process within the time period described in chapter 461 of the Oregon Administrative Rules, the determination of an effective date requires a new *date of request*.

Statutory/Other Authority~~. Auth.~~: ORS 329A.500, 409.050, 411.060, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685
Statutes/Other~~s.~~ Implemented: ORS 329A.500, 409.010, 411.060, 411.404, 411.816, 412.014, 412.049

461-180-0120 Eff. ~~4/01/21~~07/01/23
Effective Dates; Removing an Individual

The effective date for removing an individual from a *benefit group* (see OAR 461-110-0750) is one of the following:

(1) If the individual has left the *benefit group* in the current budget month because they are ineligible, disqualified, or have left the household, the effective date is:

(a) The first of the month after the *notice period* (see OAR 461-175-0050) ends, if the change will reduce benefits.

(b) The last day of the month in which the *notice period* ends, if the change will end benefits.

(2) If the individual is reasonably expected to leave the household next month, the effective date is the later of the following:

(a) The first of the month following the month in which the individual leaves the *household group* (see OAR 461-110-0210), if the change will reduce benefits.

(b) The end of the month in which the individual is expected to leave the *household group*, if the change will end benefits.

(3) When an individual in a *benefit group* of more than one individual dies, the effective date of the closure or reduction in benefits is one of the following:

(a) In the ~~ERDC,~~ REF, REFM, SNAP, and TANF programs, the last day of the month in which the *timely continuing benefit decision notice* (see OAR 461-001-0000) notice period ends under OAR 461-175-0050.

(b) For all programs not covered by subsection (a) of this section, the date of the individual's death.

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.231, 414.685, 414.826
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 414.231, 414.826

461-195-0301 Eff. ~~4-1-15~~07/01/23
Definitions

For purposes of OAR 461-195-0301 to 461-195-0350, the following definitions apply:

(1) "Action" means an action, suit, or proceeding.

(2) "Applicant" means an applicant for *assistance* (see section (3) of this rule).

(3) "Assistance" means moneys for the needs of a *recipient* (see section (12) of this rule) and for the needs of other individuals living with the *recipient* whom the *recipient* has an obligation to support which are paid by the Department (see section (7) of this rule), CCO (see section (4) of this rule), or *prepaid managed care health services organization* (see section (11) of this rule) either directly to the *recipient* or to others for the benefit of the *recipient*. "Assistance" includes both cash and medical assistance programs. "Assistance" does not include SNAP benefits. The "assistance" must be directly related to the *personal injury* (see section (10) of this rule). "Assistance" is received by the *recipient* on the date of issuance of a check for cash assistance and the date of service for medical assistance, regardless of the actual payment date by the Department, CCO, or *prepaid managed care health services organization*.

(4) "CCO" means a Coordinated Care Organization as defined in OAR 410-141-0000.

(5) "Claim" means a legal action or a demand by, or on behalf of, a *recipient* for damages for or arising out of a *personal injury* which is against any person or public body, agency or commission other than the State Accident Insurance Fund Corporation or Workers' Compensation Board.

(6) "Compromise" means a compromise between a *recipient* and any person or public body, agency or commission against whom the *recipient* has a *claim* (see section (5) of this rule).

(7) "Department" means any combination of the Department of Human Services, the Department of Early Learning and Care, and the Oregon Health Authority~~, or both~~.

(8) "Judgment" means a judgment in any *action* (see section (1) of this rule) or proceeding brought by a *recipient* to enforce the *claim* of the *recipient*.

(9) "Loan receipts" means an arrangement in which a CCO or *prepaid managed care health services organization* pays medical costs for or to the *recipient*, and the *recipient* agrees to repay the CCO or *prepaid managed care health services organization* from a recovery the *recipient* receives from a third party that injured the *recipient*, or any similar arrangement.

(10) "Personal injury" means a physical or emotional injury to an individual, for which the individual has a *claim* including, but not limited to, injuries arising from assault, battery, or medical malpractice.

(11) "Prepaid managed care health services organization" means a managed health, dental, or mental health care organization that contracts with the Department on a prepaid basis under the Oregon Health Plan (OHP) (see OAR 410-200-0015). A "prepaid managed care health services organization" may be a dental care organization, fully capitated health plan, mental health organization, physician care organization, chemical dependency organization, or CCO.

(12) "Recipient" means an individual who receives or received *assistance* or whose needs are or were included in a public assistance grant.

(13) "Settlement" means a settlement between a *recipient* and any person or public body, agency or commission against whom the *recipient* has a *claim*, and includes any agreement to pay, or payment of or compensation received by a *recipient* under Oregon Laws 2013, chapter 5.

(14) "Trust agreements" means an arrangement in which a CCO or *prepaid managed care health services organization* pays medical expenses for or to the *recipient*, and the *recipient* agrees to hold in trust for the *prepaid managed care health services organization* money from a recovery the *recipient* receives from a third party that injured the *recipient*, or any similar arrangement.

Statutory/Other Authority~~Stat. Auth.~~: ORS 409.050, 411.060, 411.070, 412.049, 413.033, 413.042, 416.351, Or Laws 2013, ch 14, § 10
Statutes/Other~~s.~~ Implemented: ORS 409.050, 411.060, 411.070, 412.049, 413.033, 413.042, 416.351, 416.510, 416.540, 416.610, Or Laws 2013, ch 14, § 10

461-195-0501 Eff. ~~3/01/22~~07/01/23
Definitions and Categories of Overpayments

This rule applies to benefits and services delivered under chapters 410, 411, 414, and 461 of the Oregon Administrative Rules.

(1) "Overpayment" means:

(a) A benefit or service received by or on behalf of a ~~client~~*recipient* (see OAR 461-195-0301), or a payment made by the Department on behalf of a *recipient*~~client~~, that exceeds the amount for which the *recipient*~~client~~ is eligible.

(b) A payment made by the Department and designated for a specific purpose which is spent by a person on an expense not approved by the Department.

(A) In the REF program, there is a rebuttable presumption that the full amount of cash benefits was improperly spent in violation of OAR 461-165-0010(8)(a) when cash benefits are used or accessed in Oregon, outside of Oregon, or on Tribal lands at:

(i) Any *liquor store* (see OAR 461-165-0010);

(ii) Any *casino, gambling casino, or gaming establishment* (see OAR 461-165-0010);

(iii) Any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment; or

(iv) Any marijuana dispensary.

(B) In the SFPSS and TANF programs, there is a rebuttable presumption that the full amount of cash benefits was improperly spent in violation of OAR 461-165-0010(9)(a) when cash benefits are used or accessed in Oregon, outside of Oregon, or on Tribal lands at:

(i) Any *liquor store*;

(ii) Any *casino, gambling casino, or gaming establishment*;

(iii) Any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment; or

(iv) Any marijuana dispensary.

(C) The rebuttable presumptions in paragraphs (A) and (B) of this section also apply when an individual in a location covered in paragraphs (A) or (B) uses or accesses cash benefits from a private bank account.

(c) A payment for child care made by the Department to, or on behalf of, a *recipient* ~~client~~ that:

(A) Is paid to an ineligible provider;

(B) Exceeds the amount for which a provider is eligible;

(C) Is paid when the *recipient* ~~client~~ was not engaged in an activity that made the *recipient* ~~client~~ eligible for child care, such as an activity of the JOBS program (see OAR 461-001-0025 and OAR 461-190-0151 to OAR 461-190-0401); or

(D) Is paid when the *recipient* ~~client~~ was not eligible for child care benefits.~~; or~~

~~(E) Has given an electronic benefit transfer (EBT) card, card number, or personal identification number (PIN) to a provider for the purpose of checking a *child* (see OAR 461-001-0000) in or out from the provider's child care.~~

(d) A misappropriated payment when a person cashes and retains the proceeds of a check from the Department on which that person is not the payee and the check has not been lawfully endorsed or assigned to the person.

(e) A benefit or service provided for a need when that person is compensated by another source for the same need and the person fails to reimburse the Department when required to do so by law.

(f) A cash benefit received by an individual in the GA or SFPSS programs for each month for which the *recipient* ~~client~~ receives a retroactive SSI lump sum payment.

(g) In the TA-DVS program, a payment made by the Department to an individual or on behalf of an individual when the individual intentionally and without intimidation or coercion by an abuser:

(A) Makes a false or misleading statement or misrepresents, conceals, or withholds information for the purpose of establishing *eligibility* (see OAR 461-001-0000) for or receiving a benefit from the TA-DVS program; or

(B) Commits any act intended to mislead or misrepresent, conceal, or withhold information for the purpose of establishing *eligibility* for or receiving a benefit from the TA-DVS program.

(2) The Department may establish an *overpayment* for the *initial month* (see OAR 461-001-0000) of *eligibility* under circumstances including, but not limited to:

(a) The filing group (see OAR 461-110-0310), ineligible student, or *authorized representative* (see OAR 461-115-0090) withheld information;

(b) The filing group, ineligible student, or *authorized representative* provided inaccurate information;

(c) The Department failed to use income reported as received or anticipated in determining the benefits of the filing group; or

(d) The error was due to an error in computation or processing by the Department.

(3) Retroactively effective April 21, 2021, for medical assistance the Department:

(a) Shall not establish an administrative error *overpayment,*

(b) Shall not establish a client error *overpayment* unless an individual received unreduced liability or unreduced benefits pending a contested case hearing decision or other final order favorable to the Department, and

(c) May establish a fraud *overpayment* when a court determines the individual made a false or misleading statement or misrepresented, concealed, or withheld a fact for the purpose of establishing or maintaining *eligibility.*

(4) Overpayments are categorized as follows:

(a) An administrative error *overpayment* is an *overpayment* caused by any of the following circumstances:

(A) The Department fails to reduce, suspend, or end benefits after timely reporting by the filing group, ineligible student, or *authorized representative* (see OAR 461-115-0090 and 414-xxx-xxxx) of a change covered under OAR 461-170-0011 or 414-xxx-xxxx and that reported change requires the Department to reduce, suspend, or end benefits;

(B) The Department fails to use the correct benefit standard;

(C) The Department fails to compute or process a payment correctly based on accurate information timely provided by the filing group, ineligible student, or *authorized representative*;

(D) In the GA and SFPSS programs, the Department fails to require a *recipient* ~~client~~ to complete an interim assistance agreement; or

(E) The Department commits a procedural error that was no fault of the filing group, ineligible student, or *authorized representative*.

(b) A client error *overpayment* is any of the following:

(A) An *overpayment* caused by the failure of a filing group, ineligible student, or *authorized representative* to declare or report information or a change in circumstances as required under OAR 461-170-0011 or 414-xxx-xxxx, including information available to the Department, that affects the *recipient's* ~~client's~~ *eligibility* to receive benefits or the amount of benefits.

(B) A *recipient's* ~~client's~~ unreduced liability or receipt of unreduced benefits pending a contested case hearing decision or other final order favorable to the Department.

(C) A *recipient's* ~~client's~~ failure to return a benefit known by the *recipient* ~~client~~ to exceed the correct amount.

(D) A *recipient's* ~~client's~~ use of a JOBS or SFPSS program support payment (see OAR 461-190-0211) for other than the intended purpose.

~~(E) A payment for child care when the client was not engaged in an activity that made the client eligible for child care, such as an activity of the JOBS program (see OAR 461-001-0025 and OAR 461-190-0151 to OAR 461-190-0401).~~

(E~~F~~) A payment for child care when the *recipient* ~~client~~ was not eligible for child care benefits.

(F~~G~~) The failure of a *recipient* ~~client~~ to pay their entire share of the cost of services or the participant fee (see OAR 461-160-0610 and 461-160-0800) in the month in which it is due.

~~(H) An *overpayment* caused by a client giving an electronic benefit transfer (EBT) card, card number, or personal identification number (PIN) to a provider for the purpose of checking a *child* in or out from the provider's child care.~~

(G~~I~~) In the REF, SFPSS, and TANF programs, an *overpayment* caused by the *recipient* ~~client~~ using or accessing cash benefits in any electronic benefit transaction in any *liquor store*; *casino, gambling, or gaming establishment*; retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment; or marijuana dispensary (see OAR 461-165-0010).

(c) A fraud *overpayment* is an *overpayment* determined to be an *intentional program violation* (see OAR 461-195-0601 and 461-195-0611) or substantiated through a

court determining the individual made a false or misleading statement or misrepresented, concealed, or withheld a fact for the purpose of establishing or maintaining *eligibility*.

(d) In the SNAP program, a provider error *overpayment* is an *overpayment* made to a drug or alcohol treatment center or residential care facility that acted as a *recipient's* ~~client's~~ *authorized representative*.

(e) In a child care program, a provider error *overpayment* is a payment made by the Department on behalf of a *recipient* ~~client~~ to a child care provider when:

(A) Paid to an ineligible provider; or

(B) The payment exceeds the amount for which a provider is eligible.

(5) When an *overpayment* is caused by both an administrative and client error in the same month, the Department determines the primary cause of the *overpayment* and assigns as either an administrative or client error *overpayment*.

(6) In the TANF and TA-DVS programs, when an *overpayment* puts the *recipient* ~~client~~ at greater risk of *domestic violence* (see OAR 461-001-0000), the *overpayment* is waived (see OAR 461-135-1200).

(7) Except as provided in section (8) of this rule, the Department establishes an *overpayment* when the following thresholds are exceeded:

(a) Administrative error overpayments concerning --

(A) Cash and child care programs, when the amount is greater than $200;

(B) SNAP open case, when the amount is greater than $100; and

(C) SNAP closed case, when the amount is greater than $200.

(b) Client error overpayments in:

(A) Cash and child care programs, when the amount is greater than $200;

(B) SNAP open case, when the amount is greater than $100; and

(C) SNAP closed case, when the amount is greater than $200.

(c) Provider error overpayments in:

(A) Cash and child care programs, when the amount is greater than $200;

(B) SNAP open case, when the amount is greater than $100;

(C) SNAP closed case, when the amount is greater than $200.

(8) There are no *overpayment* thresholds in all of the following situations:

(a) In SNAP program, if the *overpayment* was identified in a quality control review.

(b) In all programs, if the *overpayment* was caused by a *recipient's* ~~client's~~ receipt of continuing benefits in a contested case.

(c) In all programs, if the *overpayment* was caused by possible fraud by a *recipient* ~~client~~ or provider.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.081, 411.404, 411.816, 412.001, 412.014, 412.049, 413.085
Statutes/Other Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.081, 411.117, 411.404, 411.620, 411.640, 411.690, 411.816, 411.892, 412.001, 412.014, 412.049, 413.085, 416.350

461-195-0521 Eff. ~~3/01/22~~07/01/23
Calculation of Overpayments

This rule specifies how the Department calculates an *overpayment* (see OAR 461-195-0501).

(1) The Department calculates an *overpayment* by determining the amount the individual received, or the payment made by the Department on behalf of the individual that exceeds the amount for which the individual was eligible.

(2) When a filing group (see OAR 461-110-0310 and OAR 414-175-XXXX), *HSD medical programs* (see OAR 461-001-0000) *eligibility determination group* (see OAR 410-200-0015), ineligible student, or *authorized representative* (see OAR 461-115-0090 and OAR 410-200-0015) fails to report income, the Department establishes, calculates and determines the *overpayment* by assigning unreported income to the applicable budget month without averaging the unreported income, except:

(a) An individual's earned income reported quarterly from the Employment Department is considered received by the individual in equal amounts during the months identified in the report.

(b) In the ERDC, REF, SNAP, and TANF programs, an individual's actual self-employment income is annualized retrospectively to calculate the *overpayment*.

(c) In the *HSD medical programs*, if actual income is not available for the months in which an *overpayment* occurred, an individual's actual self-employment income (see OAR 410-200-0015) received during the year when an *overpayment* occurred is annualized to calculate an *overpayment*.

(d) In all programs, if verification of self-employment income is not provided to the Department following the issuance of a subpoena, or is not yet available to the individual, self-employment income from a prior year is annualized prospectively to calculate an overpayment. There is a rebuttable presumption that self-employment income from the prior year is representative of actual self-employment income for the time of overpayment. The presumption may be rebutted only by clear and convincing evidence.

(3) The Department establishes, calculates, and determines an *administrative error overpayment* (see OAR 461 195 0501) based on information initially provided by a filing group, ineligible student, or authorized representative. The Department may calculate the *administrative error overpayment* by using any of the following:

(a) Correct prospective budgeting (see OAR division 461-150 and OAR 414-xxx-xxxx) based on information initially provided; or if it results in a lower overpayment amount;

(b) Actual income; or

(c) Averaging an individual's earned income reported quarterly from the Employment Department.

(4) When using prospective budgeting (see OAR division 461-150 or OAR 414-xxx-xxxx) and the actual income differs from the amount determined under OAR 461-150-0020(2) or OAR 414-xxx-xxxx, there may be a *client error overpayment* (see OAR 461-195-0501) only when the filing group, ineligible student, or *authorized representative* withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an *overpayment*.

(5) The Department uses actual income to determine the amount of a medical assistance *overpayment* caused by possible fraud.

(6) When a filing group, ineligible student, or *authorized representative* fails to report all earned income within the reporting time frame, the earned income deduction (see OAR 461-160-0160, 461-160-0190, 461-160-0430, 461-160-0550, ~~and~~ 461-160-0552, or OAR 414-xxx-xxxx) is applied as follows:

(a) In the OSIP, OSIPM, QMB, and REFM programs, the Department allows the earned income deduction.

(b) In the REF and TANF programs, the Department allows the earned income deduction when *good cause* (see section (6) of this rule) exists.

(c) In the SNAP program, no deduction is applied to earned income if the amount or source of income was not timely reported.

(7) For the purposes of OAR 461-195-0501 to 461-195-0561, "good cause" means circumstances beyond the individual's reasonable control that caused the individual to be unable to report income timely and accurately.

(8) When support is retained:

(a) In the TANF program, the amount of support (other than cash medical support) the Department of Justice retains as a current reimbursement each month is added to other income to determine *eligibility* (see OAR 461-001-0000). When an individual is not eligible for TANF program benefits, the *overpayment* is offset by the support the Department of Justice retains as a current reimbursement.

(b) For medical assistance, the amount of the cash medical support the Department retains each month is excluded income and not used to determine *eligibility*. When an individual has incurred a medical assistance *overpayment*, the *overpayment* is offset by the amount of the cash medical support the Department retains during each month of the *overpayment*.

(9) In the REF and TANF programs, when an individual directly receives support used to determine *eligibility* or calculate benefits, the *overpayment* is:

(a) If still eligible for REF or TANF program benefits, the amount of support the individual received directly; or

(b) If no longer eligible for REF or TANF program benefits, the amount of program benefits the individual received.

(10) When an *overpayment* occurs due to the failure of an individual to reimburse the Department, when required by law to do so, for benefits or services (including cash medical support) provided for a need for which that individual is compensated by another source, the *overpayment* is limited to the lesser of the following:

(a) The amount of the payment from the Department;

(b) Cash medical support; or

(c) The amount by which the total of all payments exceeds the amount payable for such a need under the Department's rules.

(11) Benefits paid during a required *notice period* (see OAR 461-175-0050, OAR 410-200-0120, or OAR 414-xxx-xxxx) are included in the calculation of the *overpayment* when:

(a) The filing group, HSD medical programs *eligibility determination group*, ineligible student, or *authorized representative* (see OAR 461-115-0090, ~~and~~ OAR 410-200-0015, and OAR 414-xxx-xxxx) failed to report a change within the reporting time frame under OAR 461-170-0011, ~~or~~ OAR 410-200-0235, or OAR 414-xxx-xxxx; and

(b) Sufficient time existed for the Department to adjust the benefits to prevent the *overpayment* if the filing group, HSD medical programs *eligibility determination group*, ineligible student, or *authorized representative* ~~(see OAR 461-115-0090 and OAR 410-200-0015)~~ had reported the change at any time within the reporting time frame.

(12) In the SNAP program, if the *benefit group* (see OAR 461-110-0750) was categorically eligible under OAR 461-135-0505, there is no *overpayment* based on resources.

(13) In the OSIP and OSIPM programs, when an individual does not pay their share of the cost of services (see OAR 461-160-0610) or the OSIP-EPD or OSIPM-EPD program *participant fee* (see OAR 461-160-0800) in the month in which it is due, an *overpayment* is calculated as follows:

(a) All payments made by the Department on behalf of the individual during the month in question are totaled, including but not limited to any payment for:

(A) Capitation;

(B) Long term care services;

(C) Medical expenses for the month in question;

(D) Medicare buy-in (when not concurrently eligible for an MSP);

(E) Medicare Part D;

(F) Mileage reimbursement;

(G) Special needs under OAR 461-155-0500 to 461-155-0710; and

(H) *Home and community-based care* (see OAR 461-001-0030), including home delivered meals and non-medical transportation.

(b) Any partial or late liability payment made by an individual receiving *home and community-based care* in-home services or *participant fee* paid by an OSIP-EPD or OSIPM-EPD program participant is subtracted from the total calculated under subsection (a) of this section. The remainder, if any, is the amount of the *overpayment*.

(14) When an individual's liability is unreduced pending the outcome of a contested case hearing about that liability the *overpayment* is the difference between the liability amount determined in the final order and the amount, if any, the individual has repaid.

(15) For medical assistance, if the individual was not eligible for one program, but during the period in question was eligible for another program with the same benefit level, there is no *overpayment*.

(16) Credit against an *overpayment* is allowed as follows:

(a) In the GA, REF, and TANF programs, a credit is allowed for an individual's payment for medical assistance made during the period covered by the *overpayment*, in an amount not to exceed the Department fee schedule for the service, but credit is not allowed for an elective procedure unless the Department authorized the procedure prior to its completion.

(b) In the SNAP program, if the *overpayment* was caused by unreported earned income, verified child care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.

(c) In all programs, for an underpayment of benefits in the program in which the *overpayment* occurred.

(17) In the REF program, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(8)(a), the amount of the *overpayment* is the amount of cash benefits the individual used or accessed.

(18) In the SFPSS and TANF programs, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(9)(a), the amount of the *overpayment* is the amount of cash benefits the individual used or accessed.

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.660, 411.706, 411.816, 412.014, 412.049, 412.124, 413.085, 414.231, 414.685
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.404, 411.620, 411.630, 411.635, 411.640, 411.660, 411.690, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231, 416.350

461-195-0541 ~~TECH~~ Eff.
~~2/16/22~~07/01/23

Liability for Overpayments

(1) In all programs except the HSD medical, OSIP, OSIPM, QMB, REFM, and SNAP programs or a child care program, the following persons are liable for repayment of an *overpayment* (see OAR 461-195-0501):

(a) Each individual in the filing group or required to be in the filing group and the payee when the *overpayment* was incurred, except an individual who did not reside with and did not know they were included in the filing group.

(b) A *caretaker relative* (see OAR 461-001-0000) and their *spouse* (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the *overpayment* was incurred.

(c) A *parent* (see OAR 461-001-0000) or *caretaker relative* of a *child* (see OAR 461-001-0000) in the *benefit group* (see OAR 461-110-0750) and the *spouse* of the *parent* or *caretaker relative* if the *parent*, *caretaker relative*, or *spouse* was a member of or resided with the filing group when the *overpayment* was incurred.

(d) An individual determined liable for an *overpayment* remains liable when the individual becomes a member of a new filing group.

(e) An *authorized representative* (see OAR 461-115-0090) when the *authorized representative* knowingly gave incorrect or incomplete information or intentionally withheld information resulting in the *overpayment*.

(2) In the HSD Medical and REFM programs, the following persons are liable for repayment of an overpayment:

(a) Each individual in the filing group, the HSD medical programs *eligibility determination group* (see OAR 410-200-0015), or required to be in the filing group and the payee when the *overpayment* was incurred, except an individual who ---

(A) Was a child or *dependent child* (see OAR 461-001-0000) at the time of the *overpayment*; or

(B) Did not reside with and did not know they were included in the filing group.

(b) A *caretaker relative* and their *spouse* who were not part of, but resided with, the filing group or HSD medical programs *eligibility determination group* when the *overpayment* was incurred.

(c) A *parent* or *caretaker relative* of a *child* in the filing group or HSD medical programs *eligibility determination group* and the *spouse* of the *parent* or *caretaker relative* if the *parent*, *caretaker relative*, or *spouse* was a member of or resided with the filing group or HSD medical programs *eligibility determination group* when the *overpayment* was incurred.

(d) An *authorized representative* (see OAR 461-115-0090 and OAR 410-200-0015) when the *authorized representative* knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the *overpayment*.

(3) In a child care program:

(a) An *overpayment* caused by administrative error is collectible as follows:

(A) The provider is liable for a provider *overpayment* made on behalf of a *recipient* (see OAR 461-195-0301) ~~client~~ eligible for child care payments.

(B) Each adult in the filing group or required to be in the filing group is liable for an *overpayment* if the *recipient* ~~client~~ was not eligible for the payment.

(b) Each adult in the filing group or required to be in the filing group is liable for a *client error overpayment* (see OAR 461-195-0501), and a provider is liable for an *overpayment* caused by the provider. The *recipient* ~~client~~ and provider are jointly and severally liable for an *overpayment* caused by both. In the case of an alleged provider *overpayment*, a provider's failure to provide contemporaneous records of care provided creates a rebuttable presumption that the care was not provided.

(c) An adult who cosigned an application with a minor provider applicant is liable for an *overpayment* incurred by the minor provider.

(d) An *authorized representative* (see OAR ~~461-115-0090~~414-xxx-xxxx) is liable for an *overpayment* when the *authorized representative* knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the *overpayment*.

(4) In the GA, OSIP, OSIPM, and QMB programs, the following persons are liable for repayment of an *overpayment*:

(a) Each individual in the filing group or required to be in the filing group and the payee when the *overpayment* was incurred, except an individual who ---

(A) Was a child or *dependent child* at the time of the *overpayment*; or

(B) Did not reside with and did not know they were included in the filing group.

(b) A *caretaker relative* and their *spouse* who were not part of, but resided with, the filing group when the *overpayment* was incurred.

(c) A *parent* or *caretaker relative* of a child in the filing group and the *spouse* of the *parent* or *caretaker relative* if the *parent*, *caretaker relative*, or *spouse* was a member of or resided with the filing group when the *overpayment* was incurred.

(d) An *authorized representative* when the *authorized representative* knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the *overpayment*.

(5) In the SNAP program, the following persons are liable for repayment of an *overpayment* or a claim that results from *trafficking* (see OAR 461-195-0601(2)) of SNAP benefits:

(a) The *primary person* (see OAR 461-001-0015) of any age, an ineligible student in the household, and all adults (see OAR 461-001-0015) who were members of or required to be in the *filing group* (see OAR 461-110-0370) when excess benefits were issued.

(b) A sponsor of a noncitizen household member if the sponsor is at fault, for payments prior to November 21, 2000.

(c) A drug or alcohol treatment center or residential care facility that acted as the *authorized representative* of the *recipient*~~client~~.

(d) An *authorized representative* when the *authorized representative* knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the *overpayment*.

(e) For a claim that results in trafficking, the payee and the *authorized representative* when they actually traffic the benefits.

(6) Except as provided otherwise in section (7) of this rule, in all programs, both a noncitizen and the sponsor of the noncitizen are liable for an *overpayment* incurred if the *overpayment* results from the failure of the sponsor to provide correct information (see OAR 461-145-0820 to 461-145-0840). If the sponsor had *good cause* (see OAR 461-195-0521(5)) for withholding the information, the sponsor is not liable for the *overpayment*.

(7) In the SNAP program, the sponsor of a noncitizen is not liable under section (6) of this rule for payments on or after November 21, 2000.

(8) In the HSD medical programs, the November 2013 amendments to OAR 461-195-0501, 461-195-0521, 461-195-0541, and 461-195-0561 apply as of October 1, 2013.

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.087, 411.404, 411.630, 411.635, 411.640, 411.690, 411.816, 412.014, 412.049, 416.350

461-195-0561 Eff. ~~3/01/22~~07/01/23
Compromise or Adjustment of an Overpayment Claim

(1) This rule section specifies when and how the Department may compromise an *overpayment* (see OAR 461-195-0501) claim.

(a) The Department may consider a request to compromise an *overpayment* claim only if the estimated administration and collection costs necessary to collect the account in full likely exceed the current balance of the *overpayment*.

(b) The following limitations apply to the compromise of an *overpayment* claim:

(A) The authority of the Department to compromise may be limited by federal or state law.

(B) The Department may compromise a claim only once it is a *liquidated claim* (see OAR 461-195-0551).

(C) The Department may compromise a claim only if the requester has made a good faith effort to repay the *overpayment*.

(D) The Department may not compromise:

(i) A fraud *overpayment* claim;

(ii) Any *overpayment* claim, unless 36 months have passed since the requester initially was notified of the *overpayment*;

(iii) An *overpayment* claim if the debtor has the ability to repay the overpayment in full within 36 months of the request date.

(iv) An *overpayment* claim for less than 75 percent of the total amount of the claim.

(v) An *overpayment* claim if the debtor is a member, currently or in the previous 12 months, of a filing group or HSD medical programs *eligibility determination group* (see OAR 410-200-0015) that received benefits under the program in which the *overpayment* occurred.

(vi) A child care provider *overpayment* claim if the provider, currently or in the previous 12 months, received a direct provider payment for child care under division 165 of this chapter of rules or OAR 414-xxx-xxxx.

(c) The Department may allow a compromised claim to be paid in installments over a period not to exceed 90 days.

(d) During the 12 months following the date of the compromise agreement, the Department reserves the right to collect the original unmitigated claim through benefit reduction under OAR 461-195-0551.

(2) The Department may adjust a medical assistance *overpayment* that as of April 21, 2021, was a *liquidated claim*, as follows:

(a) The *liquidated claim* may be adjusted so that on or after September 1, 2021 the balance owed is $0.00, except for:

(A) A fraud *overpayment* claim,

(B) An *overpayment* claim caused by receipt of continuing benefits in a contested case, or

(C) A medical assistance provider *overpayment* claim.

(b) The Department may retain payments received before September 1, 2021.

(c) This rule section does not apply to estate administration (OAR 461-135-0832 to 461-135-0847).

Statutory/Other Authority: ORS 409.040, 409.050, 411.060, 411.404, 411.816, 412.014, 412.049, HB 2089 (2013, Section 10)
Statutes/Other Implemented: ORS 409.010, 409.040, 411.060, 411.404, 411.635, 411.816, 412.014, 412.049, 416.350

461-195-0601 Eff. ~~4-1-17~~07/01/23

Intentional Program Violations; Defined

(1) In the child care programs, a provider commits an *intentional program violation* (IPV) by intentionally making a false or misleading statement or misrepresenting, concealing, or withholding information related to ~~his or her~~their request to be eligible for a child care payment under OAR 461-165-0180 or 414-xxx-xxxx, or a claim for a child care payment.

(2) In the SNAP program:

(a) An individual commits an *intentional program violation* by --

(A) Making a false or misleading statement or misrepresenting, concealing or withholding a fact relating to the use, presentation, transfer, acquisition, receipt, possession, or *trafficking* (see OAR 461-195-0601(2)(b)) of SNAP benefits; or

(B) Committing any act that constitutes a violation of the Food Stamp Act, the SNAP program regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, possession, or *trafficking* of SNAP benefits.

(b) "Trafficking" means any of the following:

(A) The buying, selling, stealing, or other exchange of SNAP benefits for cash or consideration other than eligible food, either directly or indirectly, in complicity or collusion with others or acting alone.

(B) The exchange of firearms, ammunition, explosives, or controlled substances (as defined in section 802 of title 21, United States Code), for SNAP benefits.

(C) Purchasing a product with SNAP benefits that has a container return deposit with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount.

(D) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by intentionally reselling the product purchased with SNAP benefits.

(E) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

(3) In the SFPSS program, an individual commits an intentional program violation by intentionally --

(a) Making a false or misleading statement or misrepresenting, concealing, or withholding a fact for the purpose of establishing or maintaining *eligibility* (see OAR 461-001-0000) for SFPSS or increasing, or preventing a reduction in, the amount of the SFPSS grant; or

(b) Committing any act intended to mislead or to conceal or withhold information for the purpose of establishing or maintaining *eligibility* for SFPSS or increasing, or preventing a reduction in, the amount of the SFPSS grant.

(4) In the REF, REFM, and TANF programs, an individual commits an *intentional program violation* by intentionally---

(a) Making a false or misleading statement or misrepresenting, concealing, or withholding a fact for the purpose of establishing or maintaining *eligibility* for the REF, REFM, or TANF programs, or increasing or preventing a reduction in the amount of the REF or TANF grant; or

(b) Committing any act intended to mislead or to conceal or withhold information for the purpose of establishing or maintaining *eligibility* for the REF, REFM, or TANF programs, or increasing or preventing a reduction in the amount of the REF or TANF grant.

Statutory/Other Authority~~. Auth.~~: ORS 411.060, 411.660, 411.816, 412.014, 412.049
Statutes/Other~~s.~~ Implemented: ORS 411.060, 411.630, 411.635, 411.660, 411.816, 412.014, 412.049

461-195-0611 Eff. ~~1-1-18~~07/01/23

Intentional Program Violations; Establishment and Appeal

(1) In the ERDC, REF, REFM, SNAP, and TANF programs, an IPV is established by a state or federal court, by an administrative agency in a contested case, or by a person signing the designated form acknowledging the IPV and waiving the right to an administrative hearing. If the IPV will be established in a contested case, the Department initiates the IPV hearing.

(2) Except as provided in section (3) of this rule, there is no administrative appeal after a person waives the right to an IPV hearing and the penalty may not be changed by subsequent administrative action.

(3) A person who waives the right to an IPV hearing may seek relief in court or request a contested case hearing on the sole issue of whether the waiver was signed under duress (~~*see*~~ see OAR 461-025-0310 and 414-xxx-xxxx). If there is a determination that the waiver was signed under duress, the initial IPV penalty is void, and:

(a) If a court determines that a waiver was signed under duress, the court may determine whether an IPV occurred and the amount of the penalty.

(b) If an administrative law judge determines that a waiver was signed under duress, the Department may initiate an IPV hearing to determine whether an IPV occurred and the amount of the penalty.

~~Stat. Auth~~Statutory/Other Authority~~.~~: ORS 329A.500, 409.050, 411.060, 411.095, 411.816, 412.049, 413.085, 414.685

Statutes/Other ~~Stats.~~ Implemented: ORS 329A.500, 409.010, 411.060, 411.095, 411.816, 412.049

461-195-0621 Eff. ~~10/01/22~~07/01/23
Intentional Program Violations; Penalties and Liability for Overpayments

(1) Disqualification penalties resulting from intentional program violations and other violations of law are listed in this rule. An individual may be subject to disqualification for an *intentional program violation* (IPV) (see OAR 461-195-0601) only if the individual was advised of the disqualification penalties prior to committing the IPV. A disqualification established in another state or established in the Food Distribution Program on Indian Reservations continues in effect in Oregon.

(2) In the ERDC program, if an IPV is established against an individual through a contested case hearing, a waiver of the right to hearing, or by a state or federal court, that individual is liable for repayment to the Department of the full amount of *overpayment* (see OAR 461-195-0501) the Department has established. ~~The amount of restitution to the Department ordered by a court as part of a criminal proceeding does not lower the amount owed to the Department.~~ Payments of restitution to the Department are credited against the amount owed. A *recipient* (see OAR 461-195-0301) ~~client~~ is not subject to an IPV disqualification but is still required to repay *overpayment* amounts.

(3) ~~A child care provider found to have committed an IPV is ineligible for payment for child care as follows:~~

~~(a) A child care provider with an IPV established between April 1, 2001 and September 30, 2005 is permanently disqualified to receive payment.~~

~~(b)~~ A child care provider who has incurred an *overpayment* established as an IPV claim ~~after September 30, 2005~~ is ineligible for payment---

(a~~A~~) For six months and until the full amount of the *overpayment* is paid; or

(b~~B~~) Permanently, if ~~the Child Care Program Manager~~the Department of Early Learning and Care (DELC) finds that such ineligibility is in the public interest. The following is a non-exclusive list of reasons that support a determination of permanent ineligibility: safety concerns; or, the likelihood of future violations; or, the degree of egregiousness of any of the established IPVs; or, the degree of primary involvement in the violation by the provider.

(4) In the REF, REFM, SNAP, and TANF programs, when an IPV is established against an individual through a contested case hearing, a waiver of the right to hearing, or by a state or federal court:

(a) ~~That individual is liable for repayment to the Department of the full amount of *overpayment* the Department has established, regardless of any restitution ordered by a court.~~

~~(b)~~ Except as otherwise set forth in this section, the individual is disqualified from receiving benefits in the program in which the IPV was committed for a period of 12 calendar months for the first IPV, 24 calendar months for the second IPV, and permanently for the third IPV.

(c) In the REF and REFM programs, the individual is disqualified from receiving benefits in the program in which the IPV was committed for the remaining twelve months of eligibility.

(d) An individual found by a federal, state, or local court to have traded a controlled substance for SNAP benefits is disqualified from participation in the SNAP program as follows:

(A) For a period of two years upon the first occasion.

(B) Permanently upon the second occasion.

(e) An individual found by a federal, state, or local court to have traded firearms, ammunition, or explosives for SNAP benefits is permanently disqualified from participation in the SNAP program.

(f) An individual convicted of *trafficking* (see OAR 461-195-0601) benefits for a value of $500 or more is permanently disqualified from participation in the SNAP program.

(g) An individual is disqualified for a 10-year period, except if permanently disqualified under subsection (b) of this section, from receiving benefits in the program in which the individual committed fraud if the individual --

(A) In TANF program:

(i) Is convicted in state or federal court of having made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from two or more states under programs that are funded under Title IV or XIX of the Social Security Act; or

(ii) Is found in an IPV hearing or admits, in a written waiver of the right to an IPV hearing, to having made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive benefits simultaneously from two or more states.

(B) In the SNAP program, is found to have or admits to having made a fraudulent statement or representation with respect to the identity or place

of residence of the individual in order to receive multiple SNAP benefits simultaneously.

(5) If the TANF grant is affected by the IPV penalty imposed under this rule, *eligibility* (see OAR 461-001-0000) for and the level of SNAP benefits are determined in accordance with OAR 461-145-0105.

(6) Once a disqualification period begins, it continues uninterrupted until completed, regardless of the *eligibility* of the filing group (see OAR 461-110-0310) of the disqualified individual.

Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.816, 412.049
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.816, 412.049, 7 CFR 273.16, 7 CFR 273.18, 45 CFR 400